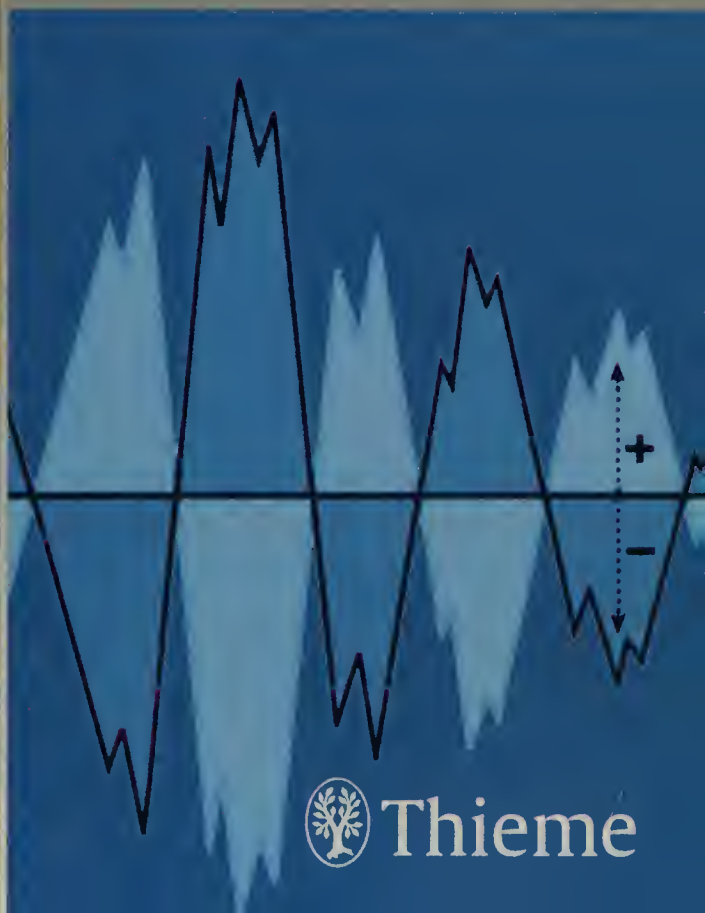
Complementary Medicine

Biophysical Therapy of Allergies

Peter Schumacher, M.D.



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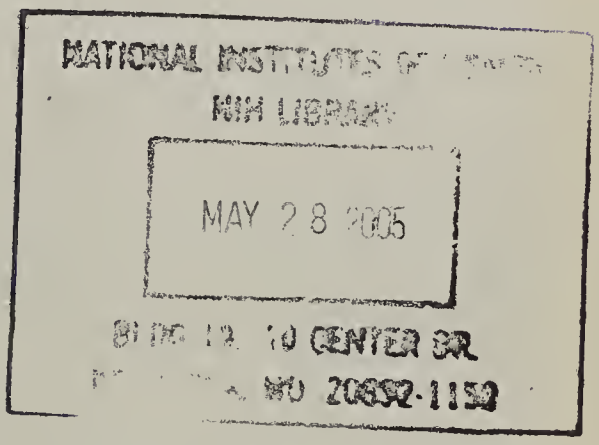
Innsbruck, Austria

145 illustrations



Thieme
Stuttgart · New York

Library of Congress Cataloging-in-Publication Data is available from the publisher

This book is an authorized and updated translation of the 3rd German edition published and copyrighted 1998 by Johannes Sonntag Verlagsbuchhandlung GmbH, Stuttgart, Germany.
Title of the German edition:
Biophysikalische Therapie der Allergien: Erweiterte Bioresonanztherapie

Translators: Bea Rataj-Arestad, Portland, OR, USA; Sharron Halvorson, Ashland, OR, USA

Typesetting by Satzpunkt Ewert GmbH, Bayreuth
Printed in Germany by Appl, Wending

ISBN 3-13-137511-6
ISBN 1-58890-257-9

1 2 3 4 5

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Preface

This book was written based on my experience as a pediatrician. Having studied and worked within the paradigm of allopathic medicine for many years, it was by no means comfortable to leave the tradition of a university career and venture into unknown territory where the safety of scientific evidence soon disappears.

At one point in my career while I was working for a university hospital, I started to feel unsettled. Having chosen the allopathic medical discipline, I was becoming increasingly specialized in a particular field of medicine. I felt, however, that I was losing what had originally motivated me to study medicine and become a physician. I was an expert in medical philosophy, which in fact seemed to serve only the scientific process (whatever that means). Its original mission—to help the ill—no longer seemed that important.

I was preoccupied with these kinds of thoughts and feelings for quite some time. Consequently, I abruptly quit my university career. Hoping to be in immediate contact with patients and realizing my ideals of a medical practitioner, I opened my own private pediatric practice.

Even then, the joy of working independently and maintaining my personal integrity soon diminished. I was growing increasingly unsettled again.

At first I employed the conventional medical training I had received at university. This was a paradigm that gave me the impression that it was primarily concerned with mastering the implementation of the list of medications sold by the pharmaceutical industry. Indeed, "fundamental chemistry" usually had a remedy for each ache and/or pain.

Having spent many years at the university hospital, I was not young in years when I began my pediatric practice—still I was optimistic. My initial optimism, however, quickly turned into despair when I saw and realized that many patients I treated according to allopathic medicine were not able to truly regain and/or maintain their health. Instead, many children developed a deceptive state of health (it might be better to say "visibly free from symptoms"). They would suffer recurring illness, often with different symptoms to those initially treated. These symptoms then required additional treatment.

During one of many sleepless nights I was thinking about how human beings existed and survived before we benefited from chemical pharmaceuticals. At that time it was not possible to treat (i. e. suppress) fever with antipyretics, infections with antibiotics, a cough with antitussives, etc.

I realized then what Paracelsus meant when he spoke about an "internal physician." Our bodies possess inherent defense mechanisms without which human beings would have become extinct long ago.

These rather depressing experiences and reflections led to the next and final step in my medical career: my turning toward holistic medicine with its naturopathic approach and its completely alternative way of thinking. This paradigm is not about suppressing symptoms, but rather about supporting the healing powers inherent in an organism. Rather than looking at histopathological end conditions, it deals with regulatory processes that directly influence the cycles of the animate and often precede the actual illness itself.

In her book *Die Quintessenz der Naturheilverfahren* (The Essence of Naturopathic Medicine), Jutta Rost writes about her introduction to this healing modality: When we get started in naturopathic medicine, the different therapy methodology itself is not that important. It is far more significant that a profound process of rethinking take place: It is not the different healing "technique" that brings success, but rather an expanded view of the course of a disease. A view we were not previously taught.

In the past physicians regarded this view as a matter of course. Modern medicine, however, usurped this way of thinking and it was forgotten. Nevertheless it is just as valid and necessary as ever!

The previously mentioned process of rethinking, changing ones attitude toward illness and all phenomena of the animate, ultimately gave me a paradigm from which to practice as well as fostering a completely new fascination with the medical profession I had chosen.

There are impressive healing results using: high potency homeopathic preparations; the oscillating balance between the opposing forces Yin and Yang according to the teachings of Chinese acupuncture; regulatory thermography offering deep insights into an organism's regulatory processes; electro-acupuncture bringing about fascinating phenomena; and finally the almost implausible possibility, electromagnetic oscillations as used by the bioresonance modality to cure illnesses. Finding out about these kinds of modalities was fascinating new territory that provided me with successful experiences. Reassured I was now able to practice medicine in a way that did not simply "treat" illness, but rather began and concluded healing processes.

I specialized in **allergies** and their subsequent problems more or less by chance. I heard about a patient with neurodermatitis, who, following a very strict diet, cured herself of her illness. In conventional medicine, neurodermatitis has always been considered a multilayered illness with an uncertain pathomechanism. It was definitely not considered a food allergy.

I kept thinking about this discrepancy, particularly because I had been unable to successfully treat patients with neurodermatitis. This had always been difficult for me. Initially, I worked with **physics-based test methods.** In many ways they proved superior to the currently practiced immunological methods.

A time of incredibly exciting, fascinating discoveries began. I came across phenomena that seemed inexplicable unless one revised one's view of the world, the body, the enigma of the animate, sickness and health, etc.

Thus I was introduced to **biophysics**, a world of visionary yet fundamental realizations, not easily accessible for a traditional physician, as he or she simply does not have the theoretical foundation. This knowledge cannot simply be understood, but, with an open mind, can be embraced. Confronted with this dilemma of not being able to understand facts which have proven to be fundamentally important, I created a technique called **thought modality** used throughout this book. It is meant to serve as an aid for an overextended mind. It may not make difficult ideas more understandable, but hopefully more palatable and practicable.

At this point I would like to ask a favor of the true experts of physics, quantum physics, and biophysics, etc. I have oversimplified many facts of biophysics in this book and am asking you to be lenient in your judgment. Please consider that a layman of physics is trying to explain phenomena which are still baffling to the experts as well as to other laymen.

I do think that it is not necessarily that critical to understand all correlations of complicated facts. It seems more significant to be able to put difficult-to-comprehend phenomena into practice. This methodology will come up continuously in this book and has proven quite useful.

For those skeptics who cannot overcome their doubts about some of the incomprehensible phenomena described, I would like to quote a sentence Hippocrates supposedly coined more than 2000 years ago:

> "If we do not understand a phenomenon, it is usually due to our limitations and is not the problem of the particular phenomenon!"

Getting involved in the physics angle of medicine completely changed my attitude toward the animate in general. Most rewarding was the immediate **application of knowledge gained through therapy**, bringing about results that previously would have been looked upon as unbelievable and unfathomable.

Over time an image emerged of a **promising new field of medicine, its effects as yet unforeseen**. This book is meant, in part, to present a sketch of that image.

Even though I am personally very committed to this subject matter, I do not want to create the impression that I am claiming sole authorship for any of the findings discussed in this book.

This book cannot be written without mentioning and thanking three men, who as pathfinders opened our eyes. They were instrumental in pioneering this methodology.

All three were independent medical practitioners without the support of the greater scientific institutions. Exclusively based on the interaction with their patients, relying upon their personal intuition, each one of them found new treatment methodologies. Way ahead of their time, they were initially frowned upon, largely misunderstood and ignored. We will reveal the actual significance of their achievements later, when we present the further development of medicine via the direction outlined in this book.

First there is **Samuel Hahnemann.** About 200 years ago he discovered (or rediscovered) not only the Law of Similars, but also showed that **information containing no actual matter** (in the form of homeopathic high potencies) can indeed have an effect on an organism. He showed that even if the principle is initially incomprehensible, it is possible to learn how to implement it in practice.

Reinhold Voll deserves a mention here as well. Using a discovery made in the 1950s to identify functional processes and energetic conditions in an organism by means of electrical measurements conducted upon the epidermal layer of the skin, he created the impressive therapy modality of **electro-acupuncture**. The information derived from and made accessible by this procedure (based solely on practical experiences) has opened important doors to areas we are just now becoming familiar with.

Last but not least we should not forget **Franz Morell**. Based on the principles of electro-acupuncture, he had the ingenious idea to use the body's information directly for therapy. In this way he created a link between the homeopathy by Hahnemann and the latest findings by Voll. Thus **bioresonance therapy**, also known as **MORA therapy**, based on the patient's own oscillations, was born. Today bioresonance therapy, tested and documented, certainly looks like one of the most significant therapy modalities of the future.

Without these practical men and, of course, the fundamental knowledge of the "Great Sages" like **Planck, Einstein** and all those erudite professors of physics, quantum mechanics, and biophysics, the biophysical aspect of medicine as expressed in this book would be as unthinkable as during Hahnemann's days.

When I talk about myself in this book, my experiences and convictions, I primarily use the plural "we" as many factors are interconnected and need to be considered in a medical practice: my excellent staff, constantly think-

ing on their feet; my patients and their families, who took heart and trusted me enough to jointly venture into often new and foreign territory.

At the same time there are many colleagues—doctors and naturopaths—whom I have had the pleasure to introduce to this new and unaccustomed aspect through a variety of seminars. Their experiences, exchange of ideas, suggestions and last but not least their enthusiasm gave me courage and supported me.

Innsbruck, Fall 2004 *Peter Schumacher, M.D.*

Part I: Foundation and Basic Terminology

1 The Physics Aspect in Medicine

Twentieth Century Medicine

In medical history, the twentieth century will be recorded as the century in which empirical medicine evolved into the scientific-based rational allopathic tradition. It is the century of cellular pathology, biochemistry, astonishing progress in surgery, and increased life expectancy made possible by newly developed treatment methodologies based on chemical, antibiotic or like methods.

Looking at its success rate, it is by all means appropriate to admire the progress made. However, one cannot help but notice that, at least in the last quarter of the century, scientific medicine has slowly started to circumambulate despite its terrific results which, to date, are uncontested.

Researching ever more complicated relationships in more and more detail is doubtlessly important and scientifically intriguing, but at the same time we run the risk of becoming super specialists who get lost in the details. Consequently, we will not be able to "see the forest for the trees." Systems thinker F. Vester describes this in considerably more scientific terms: *"Studying the individual elements of a system in more and more detail increasingly impedes the ability to recognize its patterns"* (Vester 1984). Indeed, in order to get medicine to cease this circumambulation, we need a new approach that surpasses our current ways of thinking.

According to scientific theoretician T.S. Kuhn, "*revolutionary processes, not continuous improvements*" cause real progress in science (Kuhn 1976). Kuhn coined the now commonly used term **paradigm shift**. In this context paradigm signifies theorems and methodologies employed by a particular group of scientists and regarded as valid during a specific period of time.

Physics, the basis of natural science, has seen several of those paradigm shifts in the twentieth century, as have other branches of science except medicine. "*Medicine is the exception*" (Hanzl 1990). Physicist H. P. Dürr says that "*a natural scientific view of the world mainly characterized by traits of the old mechanistic–deterministic world view of the 19th century*" dominates even today (Dürr 1988).

Development, however, does not stop. Sooner or later even medicine will have to take into consideration the revolutionary findings occurring in the basic sciences, in particular quantum physics and quantum mechanics. One can already see some rethinking starting to take place. Thanks to the "new physics" view of the world, some methods of the so-called alternative med-

icine, previously outside the mainstream of conventional medical thought, are now experiencing a revival. For example, the effect of a high-potency homeopathic remedy greater than D23 would have been unthinkable in the context of the old biochemical materialistic paradigm as it only allows for "measurable quantities." This includes the physio-scientific aspect in the observation showing that the exclusive informational content of a substance is responsible for the effect, a substance that is an **unmeasurable physical entity.**

The **physics aspect of information**, in particular, has proven extremely fruitful. It will play an important role in this book and will profoundly influence the medicine of the next century, as did cellular pathology and biochemistry in the medicine of the 20th century.

We live in a "time of change" (Capra 1983). The process of replacing materialistic paradigms with new, more flexible thought modalities requires of everyone a certain **rethinking**, or at least a **willingness to understand.** This is, of course, more difficult for people who are strongly attached to the old paradigm. A scientist who has become an expert in a particular field knows his subject matter inside and out like few others (that is why he holds the professorship). However, he is usually the one least willing to consider, let alone accept, completely different approaches.

We could say that experts are the most effective impediment to progress, or as the famous Max Planck said:

> "Newly discovered scientific knowledge does not gain acceptance by convincing its opponents. Rather they slowly fade away."

What is expected of a "new medicine" that is to shape the 21st century? It is to dismantle well-worn prejudices and create the openness required to embrace new approaches to thinking: **networked thinking** rather than solely linear thinking, including **functional and cybernetic models** in the conceptualization of how living systems work. Also, it is to finally bring about, after half a century, the acceptance of the quantum revolution in physics and its most important consequence: the **dualism of matter**. Up to now, medicine based on natural sciences functioned under the premise of physical matter that we can count, weigh, and measure. This idea was easy to understand and has not been proven wrong per se, but is only a **partial aspect of our existence**. The other aspect, not easily acceptable for a lay physicist, is the **nature of frequency oscillations** and their inherent possibilities of **interference** and **resonance.**

Admittedly, the idea that everything we are dealing with, including the human body, is supposed to comprise **tangible matter and intangible radi-**

ation is somewhat difficult to accept. Complete comprehension is not expected of a lay physicist. Specifically, however, physicians should not ignore this fact. Very few people who use their television know exactly how it operates. What they do know is that pictures and sound can be transmitted over long distances, however this may work. They accept this fact and make use of it. Medicine ought to do the same: **accept the principle and use it**. As we will see later, simple thought modalities will assist our understanding.

The Phenomenon of "Life" and Basic Physiology

Life is only possible under three conditions:
1. Matter
2. Energy
3. Information

This is the key to understanding the phenomenon of life. It seems self-evident but is slow to enter people's awareness. Scholars of natural sciences seem to have a particularly difficult time accepting this reasoning. Ever since **Isaac Newton** expounded that **matter is the origin of all existence** at the end of the 17th century, materialistic thinking was the basis for all natural sciences. The scientific materialistic aspect is also emphasized in medicine even though the subjects of its treatments and research are exclusively living beings. Scientists and physicians have studied the body, tissue, and cells in submicroscopic detail. We know of innumerable biochemical reactions that continuously take place in the body. Altogether we know a lot about the material side! Despite a cornucopia of detailed knowledge, the phenomenon of life is still incomprehensible. This way of thinking did not change much, even after the quantum revolution in the first half of the last century discovered that:

The real origin of all life is energy. Matter is just a particularly dense form of energy.

In order to truly understand life, another factor needs to be considered. Something intangible that enables the system to function. Something that is responsible for initiating, maintaining, and controlling the innumerable processes taking place on the material level. In her book, which is worth

reading and taking to heart, Jutta Rost writes about the subject of life (Rost 1990): *"How can we best define 'life'? How can we describe it? There is nothing to see, nothing to measure, nothing to weigh, and even x-ray does not show anything. This 'life per se' escapes all of our modern diagnostic and scientific methods.*

We can experience it, however: Looking at effects or non-effects, we recognize its presence or absence. A living organism has motion, functions. Animate objects react to stimulation. Inanimate objects do not react.

- *Being alive means: to be able to move.*
- *Being alive means: to be able to react.*
- *Being alive also means: to be able to regulate.*
- *Being alive also means: to be able to regenerate."*

In those terms life is not a condition but a function. This function would be impossible, even unthinkable, without integrative regulations. We know today that several million biochemical reactions per second are taking place in a regulated order in each living cell. Physicist F. A. Popp unequivocally states: *"The fact that life does not end up in a chaotic mix of chemical reactions can only be explained by the existence of control functions based upon the principles of physics."*

Any attempts to hypothesize based on biochemical principles have proven untenable to date. In any event, the slow rate of chemical reactions would not support such gigantic numbers. Moreover, any biochemical explanation would not answer the **central question about a superior coordination of biological functions**.

Popp compares biological functions with the performance of an orchestra: "*When playing at a concert, each musician is expected to play his instrument expertly. That is not the only important criterion. The quality of the artists' performance is determined by the coordination among each instrumentalist when each note is being played, in what manner, their harmonies, and on which instrument.*"

It took a surprisingly long time before scientists asked a question as obvious as the one about superior control of living processes. Scientists in the former Soviet Union were the first ones to conduct research on this subject matter. In fact, the Russian biophysicist A. G. Gurwitsch discovered **mitogenetic radiation** back in 1922. He observed that the root of an onion, which is in the process of growing, can increase the rate of cell division of another root significantly, even if the two onions are separated by glass (Gurwitsch 1932). This opened the door to the amazing field of bio-information. Based on his findings, Gurwitsch postulated the existence of a **regulating biofield**. His idea, however, was largely ignored at the time. His compatriot G. La-

khovsky, who introduced the concept of electromagnetic resonance in the transference of biological information and considered life "*to generate from and be maintained by radiation*," remained an outsider to the scientific community. At that time, people were not yet ready for the thoughts proposed by Gurwitsch and Lakhovsky. The scientific materialistic paradigm was still too omnipotent.

More than 30 years passed before physicists of the western hemisphere started to consider biophysical influences on living systems. *Biological Effects of Magnetic Fields* (Barnothy 1964) was the first publication to discuss this subject in the United States. In 1970, *Electromagnetic Fields and Life* was published by biophysicist A. S. Presman, also in the United States. During that time, the Russian biophysicists continued with their research. A summary of their work, *Ultra-weak radiation in intercellular interaction*, was published in 1981 by V. P. Kaznachejew and L. P. Michailowa. They conducted very exact and fundamental research on how biophysical information is transmitted, received, and stored in cells and organs; thus proving that electromagnetic intracellular and intercellular interactions (i. e. **electromagnetic bio-information**) were valid. These works were the first to clearly show that in order to comprehend life, "*considering metabolic functions alone (= exchange of energy and matter) is insufficient. Particularly important is the analysis of information transmitted within living systems.*"

Since the 1970s the German physicist F.A. Popp has studied the phenomena of how information is transmitted within living systems. He too encountered plenty of resistance and disrespect from the established scientific community, but was able to conclusively prove that photons transmit information within a cell and between cells. A photon is generally understood to be a light particle without mass. He showed that the DNA of living cells stores and releases photons (**biophotons**). These frequencies are inconceivably weak. Their intensity is about 10^{18} (the number 10 followed by 18 zeros) times lower than regular daylight. To prove the existence of such intracellular luminescence he developed a device called a photon multiplier. It is so sensitive that it can register the glow generated by fireflies from a distance of 10 km (16 miles). Using this technique of magnifying light to an extremely high degree, Popp was not only able to prove that photon rays are ubiquitous in all living systems, but also that:

> All biochemical reactions in living organisms are operated and regulated by ultra-low electromagnetic frequencies.

This process is regulated by an oscillation field; the human mind cannot fathom the complexity of all its information. "*If we wanted to understand the*

information content of just one single cell, we would need more than 100 years, reading day and night about the different possibilities containing information" (Popp).

Information as a Universal Entity in Physics

The term information is commonly used today. In the physical scientific sense, however, it is hard to define.

R. N. Wiener (1963), founder of cybernetics, unmistakably recognized the superiority of information as compared to matter and energy:

> Information is neither energy nor matter. It is a third, intangible entity comparable to a "message" emitted by a sender (or a system that contains the information) to a receiver.

For example, the signals transmitted may be letters, numbers, symbols or the like. In the field of bio-information, they are the **electromagnetic frequency patterns** as previously mentioned.

When transmitting information, concordance between sender and receiver is crucial. That is to say **the sender/receiver must be able to understand the message**. Let us use a common example to illustrate this. To have the desired effect, a message delivered via letter must meet a number of criteria. The receiver must be able to read, has to know the characters that were used, and understand the language. The size of the characters (i. e. individual signals) may also make comprehension difficult. Text containing characters several meters in size would be legible only from great distance. Text containing micrometer characters would be legible only using optical devices. Moreover, the receiver must not be blind.

Thus information can only be effective if it resonates with the system it is meant to influence. It must be "**suitable for the system**." This applies to the kind of signal as well as its intensity (the size of the letters as in the above-mentioned example).

Physicists (see above-mentioned photon research by Popp) have shown us that **ultra-weak** signals transmit information in living organisms. These signals are oscillations, their intensity well within the range of the so-called broadband noise. Broadband noise is signals that occur in each material caused by the movement of elementary particles, molecules, and atoms. (As particle movements are dependent on temperature, the expression thermal noise is also often used.)

To date researchers assumed that signals below the noise level do not affect anything. In any case, these kinds of signals are no longer measurable using common measuring devices and receivers.

Meanwhile it is certain, however, that biological systems selectively register information even within the frequency range and far below the measuring ability of technical devices commonly used today.

Research has shown that biological information seems to have an effect only when it is that subtle!

When experimenting with cerebral cells from chicks, the American physicist W. R. Adey (1988) discovered that they only respond to a certain frequency (about 10 Hz). At the same time, the amplitude must lie within a very specific (low) range. No reactions are measurable below or above that range. This limited range (obtained from the ratio of amplitude and frequency), within which a biological system is able to respond to electromagnetic signals carrying information, is known as the Adey window.

Apparently, transmission in the so-called molecular chain conductors is possible only if the frequency and amplitude of a signal fall within this small "window." If the amplitude of a signal is too low, it lies below the point of resonance and is ineffective. If it is too high, the protein chains will break up and the signal will be blocked (Ludwig).

The idea, intrinsic to scientific medicine, that weak signals cannot be effective when similar strong signals show no measurable results has been proven wrong.

Let us remember:

Information is neither matter nor energy. It operates in biological systems via ultra-weak electromagnetic signals and therefore plays an important part in all life processes.

Modern biophysics considers information today as *"a latent, but potent causal factor inherent in molecules, cells, tissue, and the environment. It enables all these entities to recognize, select, and instruct each other, to construct each other and themselves as well as regulate, control, and determine events of any kind"* (Oyama 1985).

Experts continue to debate the actual biophysical nature of biological information. The most modern and promising aspect for the future might be the concept of the **morphogenetic field phenomenon**. Rupert Sheldrake devised the brilliant and revolutionary thought modality of the, to date, be-

wildering process of how Nature uses fields to create forms. These fields have the ability to store the "knowledge" of individuals in a species. He defined a morphogenetic field as *"a non-material zone of influence of physics"* (Sheldrake 1990).

Sheldrake and many other physicists postulate that, besides the commonly known gravitational field that causes the force of gravity, there are a great number of other fields that structure and organize the entire universe, from subatomic particles to the farthest galaxies in some kind of hierarchical layers. Considering the latest physics research, it is acceptable to think of the cosmos as an entirely oscillating space, structured by intangible forces. The material spectrum we are used to living and operating in is just a tiny part of the whole. All of its parts are subject to these intangible forces.

All these ideas are almost inconceivable for a layperson. As previously mentioned, it is more important to accept a substantiated subject and incorporate it into one's own view of the world rather than understand it completely. In order to make the discoveries of science more accessible and palatable for laypeople, **simple thought modalities** have been introduced. They do not claim to be absolutely correct within the framework of the

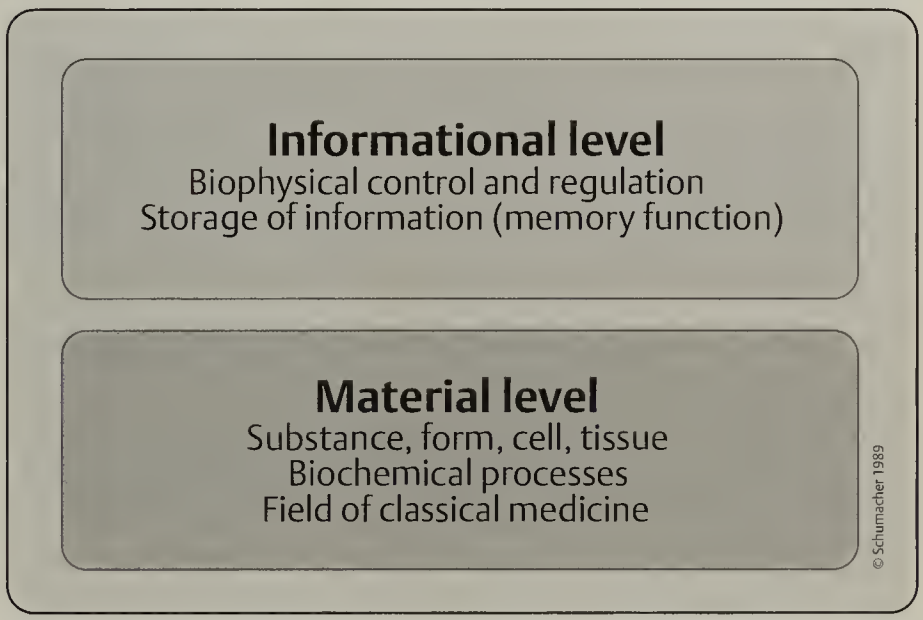

Fig. 1.1 Even though the "thought modality" of two levels separated by space is surreal, it facilitates the understanding of many biophysical regulatory processes in living systems.

presently accepted scientific paradigm, but offer tremendous illustrative ideas that facilitate often complicated interrelations.

One of these proven thought modalities is the idea of two distinctly **separated ways of operating.** Both affect and order our entire world:

- On the one hand there is the **material level**, with its dimensions directly accessible to our senses: substance, form, cells, tissue, biochemical processes, etc. This is what we are accustomed to and the premise allopathic medicine operates under.
- On the other hand there is the idea we are less familiar with of a sphere of intangible control and regulatory processes. This is the **informational level** that the material level is subject to (Fig. 1.1).

The term level was used to better illustrate the idea. We could also use the term field. This would be closer to the reality of physical science, but would place us between the opposing sides of the physicists still vehemently debating the term.

Information and Medicine

Our previous findings support the fact that everything in this world that *operates* in one way or another is subject to the controlling and regulating forces of the informational level. In terms of all areas dealing with living organisms, medicine included, this means that **all processes regarding life**, growth, development, metabolism, sickness, health, even death and decomposition **occur on the material level in biochemical ways. However, they receive their regulatory information from the level above.** Without exception, all processes pertaining to matter are subject to the informational level. This also signifies that **all processes can be influenced from that level.** Therefore a medical evaluation, be it diagnosis or therapy, that can affect the informational level has to be far superior to any method restricted to the material level!

It is easy to come to this theoretical conclusion. In practice it is difficult to obtain access to a system. We have to find a "**code**," just like with a computer, certain information that opens the system like a key and creates the possibility to influence it.

A **homeopathic simile**, for example, would be compatible information. Searching for the greatest possible congruity between the patient's symptoms and the effect of the medicine is nothing more than looking for this codification. It allows access to the regulatory level, the patient's informational system.

Homeopathy as a Physical Therapy Modality

Samuel Hahnemann, a gifted and brilliant man, intuitively recognized 200 years ago that a substance's intangible information can bring about a profound effect in the body assuming it is the **right information** at the **right potency**. The simile and potency principle belong together and are law-governed, as physicist W. R. Adey postulated 200 years later: "*Frequency (informational content) and intensity of a biological signal must lie within a certain limited range (Adey window) in order to have an effect on a living system*" (Adey 1988).

Hahnemann and the teachings of homeopathy were too far ahead of their times to be commonly acknowledged. Homeopathy existed in the paramedical arena and was not completely understood, even by its own devotees. Now we know that a purely physical scientific principle had been found empirically and developed into an effective healing method. The healing principle is based on specific physical scientific information, the physics codification, of a medicine interacting with the intangible controlling and regulatory processes of an organism.

For a medicine to work in the physical scientific framework, it is necessary to largely eliminate its chemically material elements. This is done with the potency process. As is generally known, beyond D23 a potentized substance no longer contains any molecules at all. This fact is the main argument proponents of the materialistic paradigm use against homeopathy ("*where there is nothing, there can be no effect*").

However, it is precisely this fact that is one of the main presuppositions as to why it works. Homeopathy dissects the phenomenological symptoms of illness and medicine into the minutest details and uses them as the key to open the patient's informational system. The more exactly the key fits, the better the medicine works.

Acupuncture as Informational Therapy

Acupuncture is an alternative method of treatment, but has the same goal: influencing functional processes in organisms.

The fascinating teachings of Chinese acupuncture are a particularly impressive example illustrating discoveries that were first recorded by subtly watching functional interrelations. East Asian philosophy, wisdom, and patience collected extensive knowledge regarding energetic processes and interrelationships within organisms. The knowledge of two opposite forces (yin and yang) continuously interacting as well as energy flowing throughout meridians (a complex structure subject to clear laws) opens the possibility to selectively influence harmonic and functional disruptions of the

entire system. Physical stimulation such as pin pricks, warmth, and pressure applied locally—even laser light of a specific wavelength—can bring about astonishing results when applied at specific points on the body.

In modern computer studies, I. E. Dumitrescu proved that acupuncture points empirically found and known for hundreds of years indicate "*channels carrying information between an organism and its electrical environment*" (Dumitrescu 1989). If that type of channel is stimulated by a pin prick, an electrical field that serves as an information carrier is established. This allows the exchange of information from both ends of the channel and also between channels (when treating several points).

The essence of ancient acupuncture can therefore be considered in terms of modern research to be a completely physical methodology operating in the informational and regulatory system of an organism.

Electro-acupuncture, a Window into the Future

In the early 1950s some interested physicians (R. De La Fuye, J. E. H. Niboyet in France, W. Schmidt in Germany) thought of combining the basics of Chinese acupuncture with the possibilities of modern electronics. They started to measure the classical acupuncture points electrically.

The actual founder of **electro-acupuncture**, however, is the German physician Reinhold Voll. Thanks to his diligence and extraordinary energy we now have the impressive teachings of **EAV** (electro-acupuncture according to Voll). Voll and his coworkers created a system of specific points used to measure organs and their surrounding areas. This system far exceeds the original Chinese acupuncture system. Generally speaking, electro-acupuncture uses a special device that emits very low electricity to measure the tension of an organism at specific acupuncture points. Voll was able to prove that there are interconnections between certain points and their respectively assigned organs and corresponding areas. According to Schmitz-Harbauer (1992), they realized that, *"pathological response signals at electrically significant points on the skin correlate with pathological changes in organs, systems, or subsystems."*

Measuring the acupuncture point is not exclusively meant to measure the electrophysiological properties of tissue in and around the area of the point, rather it is meant to measure the regulatory field interrelating to the point.

The ability to electrically measure functional and energetic conditions of an organism on the epidermal layer of the skin is a medical sensation. Unfortunately, it has not been recognized as such by other than a few insiders of the electro-acupuncture community.

Even more sensational and important was the discovery of the so-called **drug testing**. In 1954, Voll accidentally observed that a drug held by a patient changes the measurements at the acupuncture points. Initially, this phenomenon seems unbelievable as this change also took place when the substance was contained in a glass tube. The same happened with homeopathic high-potencies, solutions that no longer contain any molecules of the substance, but only intangible information.

Kramer showed that the "energetic frequencies" of a particular substance are transmitted via metallic conductors. He corroborated that the same information can also be transmitted without a conduction medium, solely "by air" over a short distance. He concluded that the effect of the "drug test" must be caused by "*electromagnetic frequencies, similar to radio wave*" (Kramer 1979).

The question arose as to whether the physical information of the test substance could be transmitted by a sender–receiver system. Experiments to that effect were positive. A device was subsequently developed. This device proved to be very worthwhile in clinical practice as it simplified the drug test and saved time. A brass plate attached to the sender registers the electromagnetic information of the tested substance and sends a wireless transmission to the receiver via an amplitude modulated frequency. The patient is connected to the receiver by cables and electrodes. As is customary, the acupuncture points are measured and show the same results as if the measurement were taken via direct contact with the patient and the substance.

Toward the end of the 1950s we already had a simple procedure, comprehensible for physicians, which proved that the specific physical information of a substance can be tapped. This information clearly possesses the properties of electromagnetic oscillations and unequivocally creates measurable changes in the informational system of a patient.

These findings were breathtaking and exciting, but too far removed from the well-worn path of traditional scientific thinking. They were not able to find broad acceptance in the medical community. Despite impressive success in diagnostics and therapies, electro-acupuncture remained a medical outsider. It eventually found many supporters among open-minded German naturopaths.

Unerringly, Voll expanded the method, discovering ever more correlations and new epidermal points related to organs. EAV soon became a very complex field of knowledge not easily accessible for most people. Voll's autocratic leadership style also created resistance within the EAV community. Aspirations to improve and simplify the method soon split the association. New groups started up that developed different methodologies, but never denied the intellectual heritage of Reinhold Voll.

In the early days of electro-acupuncture a physician from Nürnberg, W. Schmidt, had his own ideas and co-founded a new independent "Arbeits- und Forschungsgemeinschaft für bioelektronische Funktionsdiagnostik und -therapie" (**BFD**) (Research Community for Bioelectronic Functional Diagnostic and Therapy) with H. Vill.

The BFD developed successfully. It endeavored to simplify test methods (e. g., measuring skin conductivity, electro-impulse dermography, decoder dermography) and emphasized regulation diagnosis (Bergsmann, Maresch, Pflaum, Vill, and others).

Also interested in simplifying the EAV method, H. Schimmel pursued a different path yet again, in the early 1970s. He aimed to replace the time-consuming method of measuring many organ-specific points customary with Voll with simpler and more elegant methods. Using test ampoules of potentized organ preparations as diagnostic indicators, he found it was possible to measure just a few arbitrary points. Now known as the **Vega test**, this method has proven useful in practice and has found numerous proponents (Schimmel 1991).

Thanks to the various electro-acupuncture techniques, progress was made particularly in the diagnostics field. Now it was possible to show relationships between certain epidermal points and internal organs as well as functional correlations (i. e., between foci and other organisms). Using the method of drug testing, it was possible to predict the effect of homeopathic substances and allopathic drugs for the first time.

Bioresonance Therapy, Therapy of the Future

The most important contribution to the **therapy**, based on experiences with, and knowledge of, electro-acupuncture, was made by the German physician Franz Morell. He himself was a committed proponent of electro-acupuncture and was familiar with the phenomena observed via EAV. He knew that biophysical information, obviously oscillating, lies within the "ultra-fine"* energy range, but shows all the properties of electromagnetic waves.

At that time, the research done by Popp was unknown and hardly anyone in medicine was considering superior regulatory operations in living processes. Thanks to his seemingly clairvoyant perception and intuition, Morell recognized the correlations. He assumed that all processes within an organism must be accompanied, regulated, or caused by electromagnetic oscillations. Just as each substance shows specific electromagnetic information

* *The term ultra-fine in connection with electromagnetic oscillations was coined by H. Brügemann. It depicts the most subtle energies in living systems that are extremely weak physically (below the noise level), however quite effective biologically.*

(demonstrated by the aforementioned drug testing), in the same way, each living being possesses a codified informational base consisting of many specified pieces of operational data. This particular frequency spectrum, specific to a patient and valid only at a particular moment in time, should contain all information relevant for this living being. There are physiological, healthy "harmonious" as well as pathological "disharmonious" oscillation patterns. The latter are meant to be weakened or eliminated. Illness, therefore, is an imbalance in an organism's oscillation pattern where pathological "disharmonious" oscillations dominate! Morell's postulations were something to this effect.

He had the ingenious idea to **use the complex spectrum of electromagnetic oscillations intrinsic to a patient for treatment**. He would use electrodes to measure the electromagnetic signals of a patient. These would then be modified electronically in a device and returned to the patient as effective healing oscillations. Just as in regular electrical engineering, cables conduct the biological signals from the patient to the therapy device and vice versa.

The patient's frequency pattern is selectively (depending on the device settings) **inverted**. That is to say, it is electronically converted into its exact mirror image. Subsequently, it can be amplified, attenuated, and specific frequencies can be filtered out, etc. These procedures do not change a specific characteristic, that is to say the actual physical "code" of the frequency spectrum. The patient's frequency spectrum, when confronted by its own code, can and must react to it. As the information is the patient's own, it is ultimately **suitable to the patient's system**. This does not apply to any other known therapy modality except the true homeopathic simile. The essentially new aspect about this therapy is that it exclusively uses the body's own individual oscillations without adding any foreign energies or chemical substances, etc. This is indeed **the purest biophysical therapy possible**! (The therapy device uses electrical current only for its electronics to function. Patient signals and supply current are strictly separated.)

A completely new aspect in therapy was also to make use of a **self-regulating cybernetic feedback loop that occurred during therapy**. The therapy device does not use the patient's information collected at the beginning of the therapy throughout the course of the therapy. Instead, the device converts patient's oscillation patterns into therapeutic treatment oscillations. Their effect immediately influences the organism and changes the patient's wave patterns. Subsequently, the therapy continuously adapts itself to the new situation it initiated. Patient and therapy device together form a complete and perfect cybernetic feedback loop.

Morell first introduced the therapy modality using the patient's own signals in 1977. This was initially called **Mora therapy** (a combination of the

first letters of its inventor Morell and of Rasche, an electronics engineer and his son-in-law, who designed the first therapy device) (Morell 1987).

The development of other devices eventually necessitated a more neutral name. These days the term **bioresonance therapy** is commonly used as a collective name for this type of therapy modality. The devices developed by Rasche continue to be called Mora.

Morell's hypotheses and conclusions, initially theoretical, have proven correct in practice with regards to the content. Meanwhile the experiences of several thousand physicians and therapists with their patients speak for themselves.

A **therapy modality using the patient's own oscillations**, as does the bioresonance therapy, is automatically universally applicable. In principle, all kinds of illnesses or disturbances may be treated, be they acute or chronic, organic or functional, already manifest or without symptoms. In effect, the patient treats him/herself. Some of the information relating to the illness that comes into play is unknown to patient and therapist, but already a stressor within the body. This **prophylactic aspect** mentioned is particularly important in pediatrics. Using bioresonance therapy on a child signifies more than simply treating the symptoms; rather it acts as a preventative measure for the future.

Our experiences and observations span more than 10 000 patients, primarily children as we are a pediatric practice. Meanwhile, in addition to other specific treatments, we routinely **apply bioresonance therapy to each patient** who is in need of any therapy, for whatever reason. Particularly with children, the therapy is often extraordinarily effective. Almost daily, for several years now, parents have been bringing their sick children to our practice requesting bioresonance therapy, knowing that it usually provides rapid improvement. Concurrent treatment with homeopathic remedies and other naturopathic modalities almost always eliminate the need for the use of chemical drugs, particularly antibiotics. We use them very rarely now.

Bioresonance therapy plays an important role in "reversing" a child's susceptibility to infections and general immune deficiencies. Daily we listen to the often tragic stories of children who have not been able to escape a series of infections for months, even years. The pathogenic mechanism is the same in many cases: imprudent treatment suppressing the symptoms of each and every small disturbance, starting from infancy. This inhibits, sometimes prohibits, normal "immunological learning processes" and the establishment of effective defense mechanisms. Antibiotics have to be taken in continuously shorter time intervals. Often the child becomes dependent on the medication.

A disastrous cycle begins: an illness characteristic for the times we live in. There could not be a more typical example demonstrating the erroneous

development of our medical paradigm. The only chance these patients, primarily children (of any age), have is to reverse their therapies: Abstain from applying chemically suppressive therapies wherever it is deemed responsible. Instead, stimulate and support the body's own defense mechanisms. This is the only way to train and strengthen the immune system, which will eventually enable the patients to overcome illnesses of their own accord.

In our opinion, bioresonance therapy has turned out to be an invaluable tool for this important process of reversal. Addressing the organism from a higher level, the regulatory and informational level, toxins can be eliminated, blockages overcome, and the organism can be brought into a state of balance.

The aforementioned example, from our practice, regarding the susceptibility to infection is meant to highlight the possibilities a therapy offers that is based exclusively on the patient's own bodily regulatory codification. It has the potential to assess and treat the source of an illness by addressing the preceding or accompanying disturbances in the regulatory system. Older patients are often dealing with much more diverse and severe stressors that have accumulated over the course of their lives: disruptive conditions which are a consequence of inflammatory processes that have never healed completely or have become chronic, scars of any kind, disruption of intestinal bacterial flora or intestinal function, disturbances of the mineral or acid–base metabolism, toxic stresses caused by environmental toxins, heavy metals, etc. Finally, there are many exogenous interferences such as technical force fields, weather changes, geopathic stress, and the many unnatural accumulating influences that our modern world offers. We know of no other therapy that is more suited to our times than the bioresonance therapy with its concept of the elimination of toxins and harmonization.

The specific and impressive potential of the bioresonance therapy to **treat allergies** will be covered extensively in this book. Before going into detail, I would like to present a general overview of the method, its technique, and its manifold possibilities.

The technical aspect of the therapy is easy and in no way additionally stresses the patient. At least two electrodes, which are connected to the therapy device via cables, are placed on the patient's body. One of these cables is the input cable, usually black. It is attached to the input beaker of the device and transmits the patient's frequency patterns to the device. A second cable, the output cable (always red to avoid confusion), returns modulated therapeutic frequency patterns (signals inverted in the device or via other methods) to the patient via the output electrode (Fig. 1.2)

Electrodes come in all shapes, sizes, and forms. Each can be placed on various parts of the body. In our practice it is customary to run a **basic therapy**

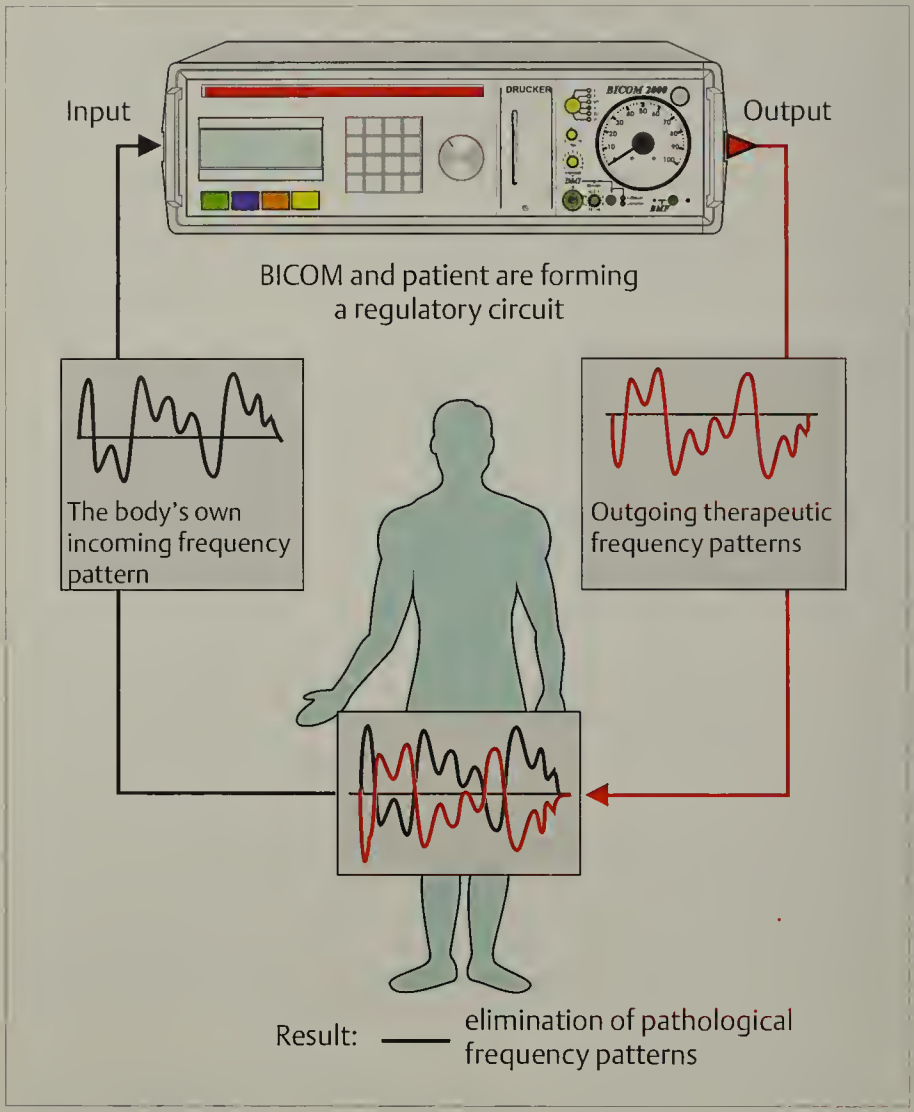

Fig. 1.2 Schematic representation of the bioresonance therapy. The patient's own frequencies are transmitted to the therapy device via cables where they are electronically modulated (i. e. inverted) and are returned to the patient as therapeutic frequency patterns.

on each patient, regardless of diagnosis and treatment indication. This serves to collect the complete spectrum of a patient's information. Everyone familiar with acupuncture knows that all acupuncture meridians start or end at the hands or feet. Therefore the basic therapy usually uses hand and/or feet electrodes. Electrodes can basically be simple conducting metal plates. The development of multicoated electrodes, which use a permanent magnetic field and act like antennae, subsequently have a deep-reaching effect (BICOM electrodes, Regumed, Inc.). They have brought about significant improvement. These magnetic electrodes are flat and come in different sizes. Flexible electrodes for uneven body parts (including the head) have proven rather useful as well.

As children are generally unable to keep their feet still, we almost always use hand electrodes. Commonly used electrodes are the brass cylinder electrodes, as is customary in electro-acupuncture (Fig. 1.3). For babies (in their mother's or father's lap), we tend to use clamp electrodes as used in electrocardiography (Fig. 1.4).

Following the basic therapy that primarily aims at altering and bringing the entire body into balance, the second step primarily directs treatment to the focal infection. Various specialized electrodes are available for this localized therapy. When treating children we found the so-called gold-finger electrode with its rounded tip most useful. It is suitable for point and surface therapy. The patients also seem to like it a lot (Figs. 1.5–7).

Special roller or point electrodes can also be used for these indications. A magnetic depth probe is used when a particularly deep-reaching effect is required (Fig. 1.8).

While the basic therapy aims to improve the patient's general condition, subsequent therapies aim to register the primary and disruptive oscillations with as much detail as possible and then address them. It is possible to treat painful areas or cramps directly or via acupuncture points and meridians. Other proven indications of the bioresonance therapy are focal infections, scar tissue, and interferences.

Placement of the electrodes depends upon the location and the type of illness. In the case of acute inflammations, the body's entire frequency spectrum is fed to the input of the device via hand or feet electrodes. The output leads to the area of inflammation. In case of chronic degenerative illnesses, the problematic area is interfaced to the input. The output is connected to the entire body via a surface electrode. This procedure, recommended by Morell more than 10 years ago, takes into consideration the basic differences as to how an organism reacts. This distinction is no longer an issue with newer bioresonance devices. They collect the information from the problematic area and carry it via a magnetic mat to the points of the bladder meridian along the back (BICOM 2000, Regumed, Inc.).

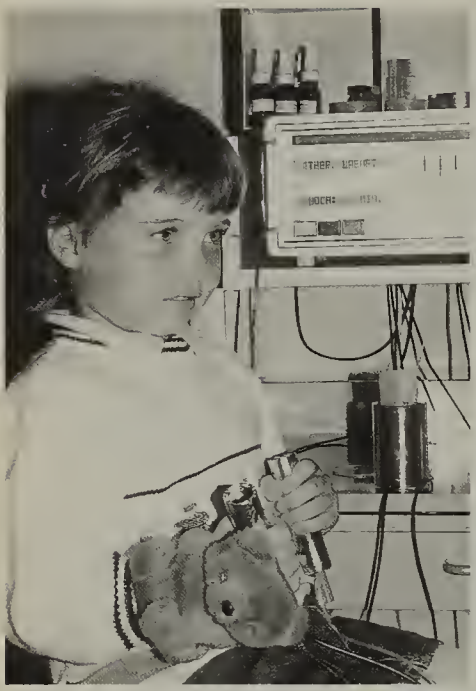

Fig. 1.3 Applied basic therapy using two hand-held electrodes. The pathological fluid (i. e. cotton swab with saliva, nasal discharge, ear fluid, throat swab) is placed in the input beaker of the BICOM device.

Fig. 1.4 ECG clamp electrodes are used for this basic therapy on a baby.

If possible, the basic therapy should already include the body's own corresponding "pathological fluid." At the least, it should be part of any subsequent therapies. We use cotton swabs with the patient's saliva, tonsil secretions, nasal discharge, puss, urine, etc. To avoid contamination of the electrode, the cotton swab is placed in a small bag of parchment paper in a beaker that is plastic on the inside, brass on the outside. It is attached to the input of the therapy device.

Using the body's own fluids, secretions or excretions, in the input of the device has proven effective and illustrates the therapy principle of physical oscillations to a lay person. This method illustrates to the patient the particular pathological portion that is part of the body's own complex frequency spectrum (received via the input cable). Consequently, the therapy signal also reflects this ratio more clearly.

Fig. 1.5 Localized therapy using the gold-finger electrode applied around the nose.

Fig. 1.6 Local therapy for otitis: gold-finger electrode in the auditory canal, ear fluid in the beaker electrode connected to the input of the BICOM device.

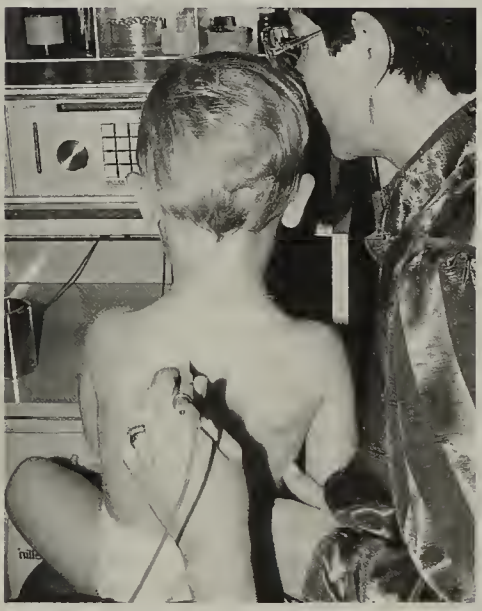

Fig. 1.7 Therapy for bronchial asthma at the acupuncture point Bladder 13 (corresponds to the lung).

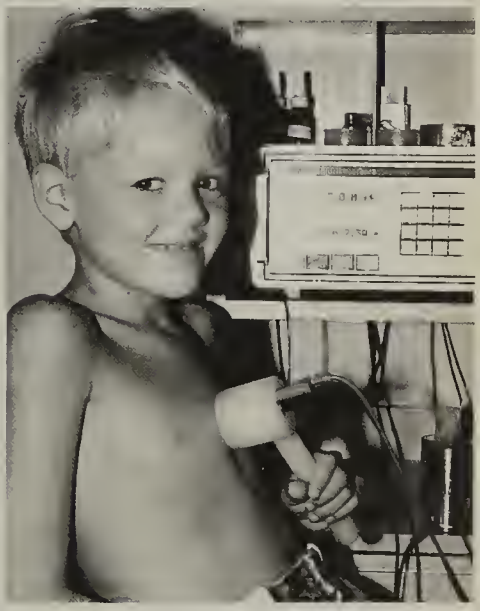

Fig. 1.8 Treating bronchial asthma using magnetic depth probe (point cv 17).

Theoretically a very interesting phenomenon, and one commonly used within bioresonance therapy, is the possibility to **charge liquids with physical information**.

Early on the developers thought of storing therapy signals, fed to the patient via the output cable of the device, in some way in order to extend the therapy's effect over a longer period of time. It turned out that water's ability to carry information was ideal for this purpose. Due to particular physical properties, water molecules are able to build "clusters" and in this way store electromagnetic information. Informational input via the patient and processed in the device is "charged" onto (that is to say stored in) a vial containing water or a water-based solution (usually diluted alcohol) that is connected to the output of the bioresonance therapy device.

This liquid now contains the patient's vibrational information used during the therapy for remote use. The patient can take it drop by drop on days when he/she is not receiving therapy. According to physical law, other carrier substances can be charged with this vibrational information, for example ferrite or iron alloys. The BICOM 2000 uses BICOM chips made from stainless steel, which the patient can attach to a body reflex zone correlating to the therapy.

Later, we will address dosage issues for allergy therapy in greater detail. For now, I would just like to point out that these drops—in no way chemically altered, which an analysis can confirm—have been transformed into a highly effective therapeutic substance for the patient.

Veterinary medicine favors this option and uses it routinely when the application of therapy encounters technical problems. Animals respond particularly well to bioresonance therapy. In many cases a single therapy session followed by taking the drops is sufficient to bring about expedient healing of all kinds of illnesses.

The therapy device has to comply with certain criteria. For many years we used the MORA device designed by Morell himself. In 1987, we switched to the BICOM device (Brügemann, Inc.) that offers many advantages to the original device.

Being able to **attenuate vibrational information** is an important advantage in pediatrics. Children usually are patients with very high electrical conductivity and respond well (according to Chinese acupuncture they are usually more yang than yin). Rather weak stimulation may cause strong reactions with these patients. Experience has shown that they often benefit more from an attenuation of the body's own oscillations rather than amplification, which was commonly used in the past.

The BICOM technology makes it possible to select specific portions of the entire frequency spectrum for the therapy. A "separator" separates the so-called **harmonic** (healthy) frequencies from the **disharmonic** (unhealthy)

frequencies. All unhealthy frequencies are converted and thus transformed into their mirror image. Harmonic frequencies can be separated and amplified selectively, or inverted in conjunction with disharmonic frequencies.

A third important setting on the therapy device is the **frequency range**. It is based on the patient's own frequency spectrum and will be returned to the patient via the device. In the experience of many bioresonance therapists, it is more effective to return a narrowed range of the frequencies registered by the patient instead of the whole spectrum simultaneously. One of the significant improvements of the BICOM device was the possibility to return such a **narrow frequency range** to the patient. This thought was based on the observation that the therapy seemed to be more effective when the therapy signal the patient received was as "pointed" or as specific as possible. Brügemann compares the method to homeopathy (Brügemann 1990). Out of the many possible potencies of a substance, one specific potency is particularly effective, whereas the others show little or no result.

In addition, the BICOM technology offers a so-called **sweeping bandpass**. The advantage of the sweeping bandpass is that all frequency ranges in question can be administered to the patient at a predetermined rate. According to C. Smith (1985) "*each body reacts to beneficial frequencies in a very short time, while harmful frequencies require a significantly longer time to become effective.*" Selecting the correct rate for the frequency sweep ensures that beneficial frequencies will positively influence the body, while harmful frequencies are passed before they can have a negative effect. This makes optimal use of a patient's therapeutic frequency range whereas the unsuitable frequencies remain ineffective.

While in the past it was necessary to set the frequency range manually, the sweeping bandpass considerably simplifies setting the frequency range, at the same time increasing efficacy and safety.

Early on Morell observed that the required therapy time can be shortened if the therapy course is interrupted by short breaks. The body seems to react favorably when allowed a break to regulate those impulses received.

Based on these observations, an **interval setting** was added to the therapy device. Initially it was variable and selected manually. Over the course of the years a rhythm of 3-seconds therapy time with a 1-second break has proven to be a favorable setting. This rhythm is now permanently integrated into the device. It is possible to switch to a continuous therapy mode when needed for special indications.

The **duration of therapy** can be set using the device. For adults it is usually 3–8 minutes. For children it varies according to age: babies one-fourth, infants one-half, and school children three-quarters of the time intended for adults.

The therapist individualizes the therapy to the patient and his/her illness. The following settings are adjusted on the device:

1. The type of frequencies out of the entire spectrum that are returned to the patient (harmonic, disharmonic, or both), selectively inverted as a mirror image.
2. Amplification or attenuation of individual signals.
3. Frequency selection (frequency sweep or individual frequency setting).
4. Intermittent and continuous therapy.
5. Duration of therapy.

When choosing one of the **therapy programs** stored in the BICOM device, manual selection of the above data is not necessary.

This book does not aim to explain in detail all the possibilities and facets of bioresonance therapy. Anybody who is interested in applying this resourceful, ingenious therapy should attend training seminars to obtain the necessary skills. Further information can be obtained from Regumed, Inc., Gräfelfing, Germany.

The most important, basic precepts to understand this methodology are summarized in 10 short sentences as follows:

Basic Principles to Aid the Understanding of Bioresonance Therapy

1. In and around the human body are electromagnetic frequencies. These are superior to the biochemical processes and regulate them. Cells and organs oscillate at certain frequencies. This creates the **frequency spectrum** of an organism.
2. In addition to physiological frequencies, each human being also has **pathological frequencies** caused by toxin stressors, injuries, inflammations, lingering illness, iatrogenic damage, etc.
3. Together physiological and pathological frequencies are called the **patient's individuated frequencies**.
4. The patient's individuated frequencies can be **picked up** from the surface of the body and **channeled to a therapy device via cable**.
5. The patient's individuated frequencies are transformed into **therapeutic frequencies** using modern electronics (BICOM device). No technically or otherwise generated frequencies are added.
6. The BICOM device returns the therapeutic frequencies to the patient. Therapy takes place **within the patient's body**, not within the therapy device.

7. Therapeutic frequencies **reduce the pathological frequencies** in the patient's body. They also stimulate and/or strengthen physiological frequencies.
8. Bioresonance therapy aims at reducing and/or eliminating pathological frequencies as well as strengthening physiological frequencies.
9. Once the **biophysical energy situation** improves, **biochemical processes improve** and become more **balanced**.
10. The chief objective of bioresonance therapy is to **activate the body's own regulatory powers** and to free the body from disturbing pathological influences so it can restore itself to a state of health.

Prospectus

Popp once pointedly remarked "*we live in an ocean of electromagnetic interplay that we know little about*" (Popp 1984).

Indeed it is not necessary to understand everything in detail in order to use it. For centuries ships crossed the oceans, long before Archimedes discovered why they did not sink.

The rules of Chinese acupuncture were established without knowing what happens in the body physically. Homeopathy proved an effective healing method even though it was not possible to explain its workings to doubters for 200 years.

Slowly but surely we are opening doors to areas that initially seemed like fantasy and in the realm of the impossible, the reality of which, however, we experience daily in practice. Electro-acupuncture, particularly bioresonance therapy, allows a vision of a medicine that is able to treat illness before it actually manifests, that heals without side-effects or suppression of symptoms. Lastly, a medicine that eliminates stressors rather than adds them and creates a state of health that promotes harmony in the entire living being, and not simply the absence of disease. Decades will likely pass until the findings of modern biophysics become part of a newly formed medical paradigm. It will be impossible to stop the fundamental shift in thinking. Developments in nature and science appear on the horizon, have their pathfinders and predecessors, but only when their time has come will they prevail.

As Victor Hugo aptly stated:

"Nothing has more power than an idea whose time has come."

We believe that the significant progress in medicine in the 21st century will be made in the field of biophysical research. The correlations in the field of bio-information are presently barely understandable. Nevertheless, we can already clearly see the implications and benefits physicians and patients can obtain from the discoveries in quantum physics and biophysics. The physical diagnosis and treatment of allergies serves as an excellent example.

Today we are in a position to largely eliminate allergic reactions using exclusively physical methods. The "how and why" will be discussed in the following chapters.

2 Allergy: A Medical Phenomenon

Defining the Term Allergy

The term **allergy** is not merely a modern catchword; it represents a major problem of our times that has yet to be overcome.

It seems that the increasing number of allergies worldwide is just as much part of our current environment as air pollution, dying forests, or similar developments that are not being adequately dealt with. Their source may also be the same.

The world we live in today is not the one we were made for. Our natural resources to adapt have long been exhausted and overextended. We are exposed to a variety of stressors for which we do not possess any naturally inherent adaptation mechanisms.

Clinical ecology calls this "**total body load**," that is to say the total of all chemical, alimentary, physical, and psychological stressors and/or damage to which human beings are exposed via the environment. An organism inevitably reacts to these stressors by creating manifold illnesses that manifest themselves—though only partly—as **hypersensitivities of a type of allergy**.

Klemens von Pirquet, a famous pediatrician in his time, coined the term allergy about 100 years ago. In the classical definition, accepted even today by scientific allergology, allergy signifies:

> "Sensitization causing a different reaction to a substance."

Becoming increasingly popularized, the term lost its accuracy over the course of the years and is now used very generally for any kind of hypersensitivity, intolerability, or rejection.

Even in medicine the term is used vaguely and more often erroneously. In particular the proponents of the previously mentioned "**clinical ecology**"—researchers mainly established in the United States and working primarily empirically—use the term rather broadly. It is believed that hypersensitivities to foods and chemicals are the main causes of chronic illnesses and psychological disturbances (Randolph 1962, Mackarness 1986, Runow 1987, etc.). The term allergy is increasingly applied to any damage or negative influences in any way connected to the environment. It would be more correct to describe this as a **clinical ecological syndrome**. This mixing of terminology often causes misunderstandings with the supporters of clinical

immunology who endeavor to limit the term to verifiable **immunological processes.**

The discovery of **immunoglobulin E** (IgE) clarified the interfacings of the actual allergy.

"Allergic reactions are caused by the allergen interacting with IgE antibodies, bound to mast cell receptors and basophilic leukocytes, and the subsequent release of mediators" (Ring 1982).

Hopes to be able to clearly delimit and declare allergic illnesses as such, by means of IgE test methodologies, were only partially realized. Thanks to many exact and controlled studies, we know now that the correlation between a positive test result of specific IgE antibodies (e. g., through serological and/or skin tests) and clinical symptomatology is often insufficient to draw definitive conclusions. Many **food allergies** fall into this category. Due to frequently negative test results, food allergies are often classified as non-allergic or pseudo-allergic even though all other criteria of an allergy are present.

A clear and scientifically **unmistakable definition** of the term allergy remains **illusive.**

Clinical allergology often uses the expression **atopic allergies**, which includes the genetic aspect. The term atopy, coined by Coca and Cooke in 1923, was meant to describe different experiences with allergies in human beings. These observations have also been made with animals. The term was finally accepted as the description for a congenital and inherited susceptibility to an allergen. The patient is sensitized to certain allergens and reacts to them according to clearly defined pathologies such as **allergic asthma**, **urticaria**, **hay fever**, **perennial allergic bronchitis**, **rhinitis**, and **neurodermatitis**.

The common thread among these clinical pictures is that they are undoubtedly allergic in nature and occur individually or combined in human beings that are genetically predisposed to allergies (atopics). To be included in this group a positive test of specific IgE antibodies is not absolutely necessary, as the example of neurodermatitis shows. Due to negative test results, dermatologists consider neurodermatitis a skin disorder of unknown origin. Many allergologists, however, regard it as an allergy as it is clearly an atopic illness. In this book, we use the term allergy in the sense of **atopic allergies**. We are following in the footsteps of the classical definition of clinical allergology. However, here we emphasize the **characteristic** and **undoubtedly allergic pathology**. We do not require positive IgE test results, whether serologically or otherwise obtained. As regards the necessity of a

clear definition of the term allergy, we concur with the English immunologist D. Freed:

> "Anybody who uses the word 'allergy' ought to make sure that all participants in the conversation share the same definition of the term!" (Freed 1986)

Allergens throughout Medical History

If historians are to be believed, allergies are as old as human beings. Old writings report that allergies are not new to our times, even if diagnosing their symptoms depended on the zeitgeist and ideas of the day.

The first record of an anaphylactic allergic reaction and ensuing death is from the third millennium BC. The Egyptian Pharaoh Menes died from a wasp sting in 2540 BC. The Papyrus of Ebers, dating back to about 1600 BC, clearly describes allergic asthma. Hippocrates, however, coined the actual term asthma more than 1000 years later.

Physicians of Classical Greece seemed to have been quite familiar with allergies, even though they did not know what caused these mysterious reactions. Ptolemaios called them **idiosyncrasies**. At the time this was meant to describe a particular mix of bodily fluids that denoted neither a state of health, "eucrasia," nor illness, "dyscrasia."

Even the powerful emperors of Rome had allergies. Both Augustus and Claudius are said to have had symptoms like asthma, chronic rhinitis, and atopic eczema.

Historians report that Richard III broke out in a rash and had edema after eating strawberries. The symptoms were thought to be the effects of poisoning. The king used this opportunity as a welcome excuse to have a disliked lord executed on grounds of poisoning.

Hay fever was already well-known in the Middle Ages. Occurring when roses were in bloom, it was called rose fever. Hay and grass were also suspected causes of the peculiar seasonal symptoms. In the 19th century, people were already talking about "hay fever" without knowing any details. In 1873, experimenting on himself, the English physician C. H. Blackley was able to prove that pollen in the air caused the mysterious symptoms. He was the first to conduct skin and provocation tests. His exact experiments introduced a **new era of allergy research**: The steady illumination of the various pathophysiological allergy mechanisms was brought about by scientific studies and experimentation. The independent specialties of clinical immunology and allergology came into being. By the end of the 20th centu-

ry it was difficult to keep abreast of the enormous field of knowledge they had developed.

Scientific and Clinical Allergology

Scientific research conducted over the course of almost a century has created an incredibly impressive database of knowledge. One would think this sufficient to solve, if not all, at least the most important practical problems relating to allergies. Surprisingly, and maybe significantly, this is not the case.

Millions of allergy sufferers know very well that true healing is elusive despite many time-consuming therapy attempts that are often dangerous for and place stress on the body. Hundreds of thousands of physicians, even the most specialized allergologists, experience daily the frustration of not being able to provide relief to their patients.

Very recently, W. Aberer, an experienced clinical dermatologist and allergologist, has resigned himself to consider "*allergies a chronic illness that cannot be cured and for which medicine has not yet discovered an easy solution.*" He laments therefore that, "*people are increasingly turning to alternative medicine whose motives are often, this is well known, commercially driven*" (Aberer 1992).

Beginning with **diagnosis**, clinical allergologists experience practical difficulties and unresolved problems.

The discovery of immunoglobulin E in 1967 (by K. and T. Ishizaka at the same time as Johansson and Bennich) made it possible to prove allergenically relevant factors in the patient's blood. However, the initial great expectations that positive proof of specific IgE antibodies invariably signify a manifested allergy to a particular substance soon had to be scaled back considerably.

Leading experts of allergology agreed meanwhile that a correlation between positive proof of specific IgE antibodies and clinical symptoms may not always be sufficient to conclusively diagnose an allergy. In a broad study of 5000 randomly selected people who did not have any apparent allergies, more than one-third showed positive skin reactions to one or more of the common allergens.

"These people produce specific IgE without developing allergic symptoms" (Roitt 1987).

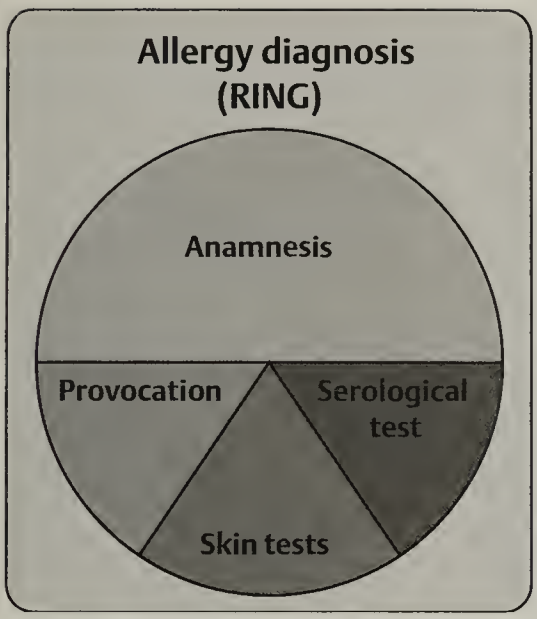

Fig. 2.1 Importance of anamnesis in allergy diagnosis (according to Ring).

It is generally known that skin and blood tests, particularly with regard to **food allergies**, are unreliable (Reimann 1989, Wahn 1987 etc.).

"We have to admit that we do not have good test methods when it comes to foods" states Aberer. He goes on to say that in the case of in vitro methods showing positive test results of numerous differing IgE antibodies in the same patient, which occurs quite often, "*allopathic medicine is unable to determine which ones are relevant*" (Aberer 1992).

Again and again **anamnesis** is emphasized. According to Ring, it amounts to a good 50 % of the diagnosis (Fig. 2.1). Aberer estimates it to be as high as 80 %.

We will show later on that, due to the masking effect, a patient often does not know that he or she is allergic to a particular substance. This occurs mainly with the most important food allergies, that is to say chronic forms where allergens are ingested daily. According to Ring, in vivo test methods designed to provoke an allergy or eliminate allergens are critical to confirming the existence of a food allergy. Various elimination diets as well as the search for allergens by adding suspected allergy-provoking foods may cause problems for the patient. Besides taking a long time, they are not reliable and cause additional stress on the patient's body.

The **intragastric method of provocation using endoscopy** (IPEC) exemplifies the difficult situation that arises when diagnosing foods allergies

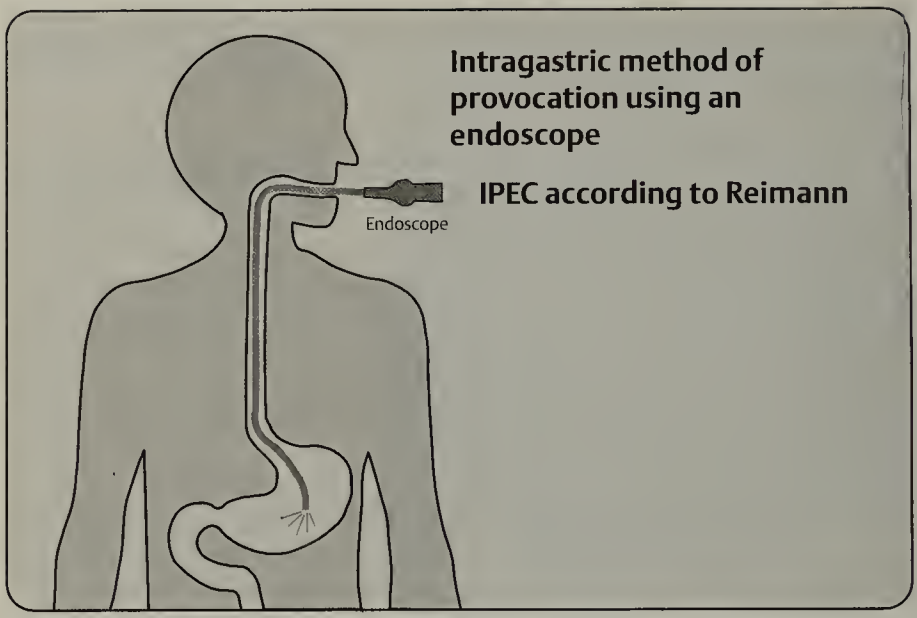

Fig. 2.2 Intragastric method of provocation using an endoscope (IPEC according to Reimann).

(Fig. 2.2). The suspected allergen is endoscopically introduced to the gastric mucous membrane whose reaction is then assessed macroscopically and microscopically. At the same time the antihistamine release can be measured in loco. Undoubtedly this heroic method was developed only because the conventional immunological diagnosis of food allergies is essentially ineffective.

We do not want to dispute the serious attempts of allergologists to solve the manifold problems concerning allergy diagnosis. However, viewed critically, a certain perplexity and helplessness must be acknowledged.

Serological in vitro methods as well as different tests on skin and mucous membrane are part of the daily allergological routine. Even though they form the indispensable basis of clinical allergology for numerous physicians, clinicians, and specialists, it does not mean that the results are relevant.

Erroneous negative as well as positive test results are more common than admitted.

A typical example is the allergy to chicken egg proteins, which is often overrated. According to a study by Hattewig and Kjellmann (1984), specific IgE antibodies to chicken egg protein can be found in almost one-third of all **healthy** children after they have started eating chicken eggs. Bear in mind that these are children who never had any allergic symptoms until the time of the examination. Minute quantities passed on through the mother's milk commonly appear as sensitivities to chicken egg protein in breast-fed babies. Serological test results are positive, but no symptoms can be observed (Gerrard 1979). In the case of babies and infants, initial contact with a substance seems to be sufficient to stimulate the creation of specific IgE antibodies. These are not necessarily a definitive sign of a clear allergy.

Obviously other factors play a role, besides the creation of antibodies, for allergy symptoms to occur. This conclusion led to the **theory of allergy manifestation.** It purports that an allergy does not create symptoms unless immune activity exceeds a certain point. When this threshold is reached depends on the encompassing circumstances such as allergen exposure, genetic predisposition, and the ability to create IgE antibodies (IgE low responder, IgE high responder). Various circumstances may play a role such as temporary IgA deficiency, lower suppressor T-cell activity, and viral infections. The latter may expedite the release of histamines from basophils. By no means evident, the postulated factor obviously essential to manifest allergies was called **factor** x to express a hypothetical mechanism (Fig. 2.3).

The **therapy** itself is also confronted with considerable unsolved problems despite worldwide research and significant financial investment.

In the words of the German immunologist W. Müller, allergy treatment aims to "*develop immunological tolerance (to the allergen) over the course of many years.*" He continues with resignation: "*To date we have no therapeutic modality that has achieved this even though individual cases show an eradication of symptoms after avoidance of and subsequent renewed exposure to the allergen*" (Müller 1987).

Meanwhile we have experienced that the avoidance of allergens has been successful in only a few cases. The significance of "*avoidance even to the point of complete isolation from the allergen*" was unknown and consequently had not been taken into consideration.

In contrast to avoidance, clinical allergology uses **hyposensitization** to treat allergies. The patient frequently receives small amounts of the allergen. The goal is twofold: to prevent the appearance of allergy symptoms and/or for the patient to be able to tolerate a higher dose when he or she comes into contact with the natural allergen. True healing through hyposensitization treatment has yet to be documented. The effectiveness of this

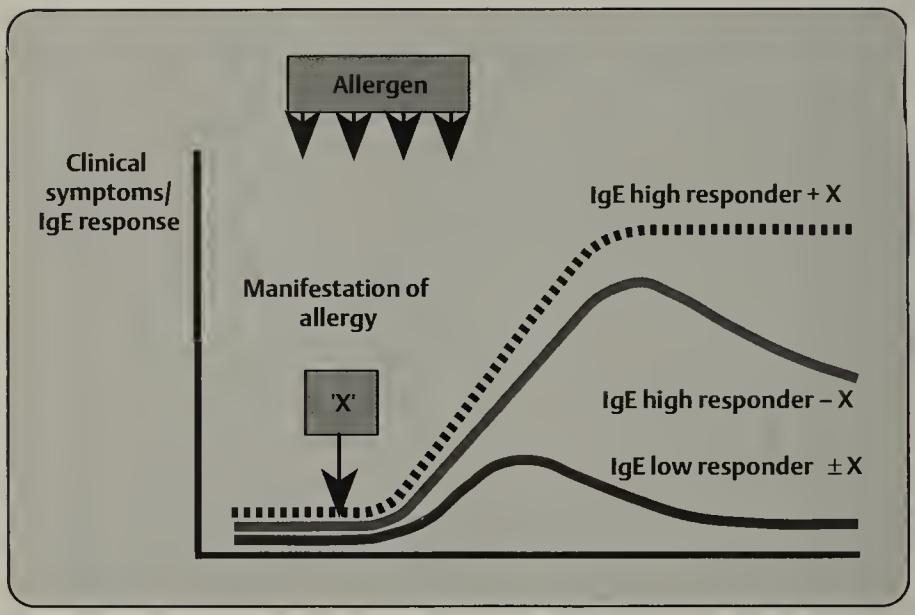

Fig. 2.3 The theory of allergy manifestation (according to Roitt et al. 1987).

therapy has been the subject of discussions since the first controlled study by Frankland and August in 1954 (Uhlmann).

The decrease in IgE antibodies concurrent with an increase in immunoglobulins of type IgG (Djurup and Osterballe 1984), often apparent with this therapy, bear little correlation to the clinical symptoms. Its significance has yet to be explained.

The efficacy of hyposensitization immunotherapy has been unequivocally proven solely in the case of bee and wasp allergies. This is very risky for the patient and currently is generally only recommended as in-patient treatment in specialized departments with specialized equipment, staff, and experience.

Decreasing patients' sensitivity has been somewhat successful with **pollinosis**. Generally, however, therapy extends over a very long period. There is always the risk of a fatal anaphylactic reaction.

Oral treatment with liquid allergen extracts is less risky. Even though it has been proven to be utterly ineffective (Urbanek et al. 1983, Wahn et al. 1987), it is still widely practiced, particularly in pediatrics, due to a lack of effective alternatives.

Food allergies, one of the most important groups within allergies, *cannot* be treated by hyposensitization. To date there has been no documented success story.

Industry undoubtedly plays a big role in overestimating treatment via hyposensitization, painting an exaggeratedly positive picture of hyposensitization treatment.

Commerce with regards to allergen extracts amounts to billions of dollars worldwide. It is not surprising that representatives of allergen-producing pharmaceutical companies regularly appear in the physician's office optimistically touting their company's products as effective therapy treatments. At the same time they may occasionally forget to mention less optimistic reports found in technical literature.

Chemical drug therapy is often aggressively propagated due to similar interests. Chemical substances administered in response to IgE-causing allergies of Type 1, without exception, only prevent the onset of symptoms or suppress them (Coombs and Gell 1963). This fact is readily overlooked or not mentioned. Chemical drug therapy is unable to alter the actual mechanism of an allergy. This applies to various antihistamines (H1 receptor antagonists) as well as mast cell stabilizers (DNCG, NAA-glutamic acid) and corticosteroids, the most potent and problematic of all allergy pharmaceuticals.

It becomes apparent that to date, clinical allergology possesses **only two therapy modalities** that address the cause: the avoidance of allergens and hyposensitization. Even though they have been used routinely for millions of patients, neither is completely effective. W. Müller fittingly sums up the current situation of allergology as follows: "*The therapeutic dilemma in allergology can be clearly seen in the opposing therapy modalities of the avoidance of allergens and hyposensitization. Both act under the same premise, to induce immunological tolerance to the particular allergen. We still do not know which one of the two therapies might be the more successful*" (Müller 1987).

Against this globally frustrating background, the assertion that there is an incredibly easy way to **heal** allergies using exclusively physical means, as previously defined, sounds like malevolent provocation. Could it be possible that the impressive knowledge clinical allergology has amassed is worth nothing? Can many thousands of serious researchers be mistaken?

In this, as in many similar situations, a response to these questions is futile as it would be based on "**either/or**" rather than "as **well** as."

The "either/or" thinking between allopathic medicine and the so-called alternative methodologies is one of the big, seemingly ineradicable misunderstandings.

We do not need physicians to discard their allopathic knowledge. This knowledge has contributed to a doubling of the average life expectancy, victory over numerous diseases, epidemics, and other threats to mankind.

We need physicians who are willing to **supplement** their knowledge. They have to be open-minded in order to enter new dimensions, even if these are initially surprising and hard to understand.

In the following chapters we attempt to explain what we mean by "a new biophysical aspect of allergy." We also want to present resultant, impressive, and to date unexploited practical opportunities.

3 Allergy from a Physics Point of View

The Physics Code: An Ubiquitous Principle

One of the most important, yet difficult to understand discoveries of the Quantum Revolution is the law of **wave–particle duality.** It is

> the concept that each substance consists of matter as well as particles.

Matter is directly available to us via our senses. It is measurable, tangible, and familiar to us. The intangible aspect, characterized by physical oscillations, cannot be recognized by our senses or, to date, any measuring device that we know of. This important—and, for the operation of our cosmos, indispensable—aspect is often overlooked and/or its existence questioned or negated.

The introductory chapters already briefly mentioned the significance this information carries for our world view, particularly for modern medicine. Using certain techniques, it is indeed possible to make this intangible portion visible. It can be used for diagnostic and therapeutic purposes. Here, too, the rule applies:

> We do not need to understand each phenomenon of our world in detail in order to use it!

To understand the many techniques of so-called holistic medicine—in this particular instance, the bioresonance methodology—the intentional simplification of the idea of ubiquitous physics "codification" has proven to be a useful practical base of information to work from.

For us **ubiquitous physics codification** signifies the fact that besides having a chemical–material aspect, each substance and animate or inanimate system, from subatomic particles to the greatest cosmic galaxies, also possesses an independent **informational aspect** intimately **linked** with the former.

From a physics point of view each atom, molecule, cell, organ, organism, etc. is a system based on physics with particular properties and very specific frequency information. The latter is very obviously a **spectrum of ultra-weak electromagnetic frequency information**. It is composed of the frequency spectra of each individual part of the system, including the last subatomic particle.

Biophysicist R. Sheldrake is convinced that these are essentially physical field phenomena and speaks of a "*hierarchy of physical fields*" that integrate into one universal field (Sheldrake 1990). One of the leading experts in energetic medicine, R. O. Becker, appropriately characterizes the situation as "*fields within fields within fields*" (Becker 1990).

Irrespective of the experts' debate on the physics definition, it appears entirely justified to call this system-specific information a "biophysical codification." After all, it is unique, highly complicated frequency information applicable only to one particular system. Meanwhile, there are methods that make it possible to identify any system (any arbitrary substance, living being, etc.) by means of exactly this codification.

Let us remember:

Besides having a chemical–material aspect, each physical system in our cosmos also possesses a physics codification, very specific to its system. This codification appears as a spectrum of ultra-weak electromagnetic frequency information.

Knowledge and acceptance of this thought modality is the most important prerequisite to comprehend any further elaborations on this subject throughout this book.

Allergy: A Phenomenon of Biophysical Information

"*Allergic reactions are caused by the allergen interacting with IgE antibodies, bound to mast cell receptors and basophilic leukocytes, and the subsequent release of mediators*" (Ring 1982). This is how the renowned German allergologist J. Ring summarizes the knowledge of allopathic allergology regarding Type I allergy: a historically proven theorem, accepted by all experts, regarding a mechanism that undoubtedly only takes place on the level of substantive biochemical immunology. How and where could there be space for physical mechanisms?

Initially, it seems rather unbelievable, or at least surprising, for us to assert that **allergy is nevertheless a largely biophysical informational phenomenon**. There is, however, clear-cut proof for this assumption:

1. If the material level conditioned allergies exclusively, it would be unthinkable to use the informational level for allergy testing. Among these test methods are: tests applied by electro-acupuncture; VAS (Vascular

Autonomic Signal), the method developed by the French physician Paul Nogier within the framework of auriculomedicine; the different techniques applied by kinesiology; and, of course, our preference, the allergen resonance test.

2. Exclusive use of allopathic methods for allergy testing would be no explanation for the therapy successes yet to be discussed.
3. C. Smith and his team's sensational experiments at the University of Salford, England, are the most important and irrefutable proof to date. He examined individual people's reactions while in contact with their allergens. The group was exclusively made up of hyperergic patients, that is, people extremely sensitive to numerous substances (Smith 1989).

Initial research was based on the findings of J. B. Miller. He discovered in the 1970s that skin reactions of hypersensitive patients tested by means of the prick test did not diminish with gradual dilution of the allergen as was expected. Rather, among the many dilutions causing positive skin reactions, there would be one that suddenly caused no reaction at all. This result was reproducible. This particular dilution of the allergen, called "neutralizing dilution," was the one that eliminated the symptoms when injected into the patient. Jean Monro and her team used this discovery in the early 1980s. They were surprised to find the same neutralizing effect when the patients held a glass ampoule containing the neutralizing dilution specific to them in their hand, even if the contents of the ampoule had been frozen (Monro 1984).

Monro and Smith eventually discovered that besides being hypersensitive to various chemical substances, foods, environmental toxins, etc., many people also react to particular electrical frequencies displaying the same allergic reactions. This is called electrical hypersensitivity.

Smith experimented with hypersensitive patients who reacted very strongly after only a few seconds of contact with the allergen. Symptoms experienced were strong headaches coupled with visual impairment, sudden paralysis in the legs, inability to move, confusion, inability to speak, or acute pain in arms, legs, joints, etc. These symptoms occurred after contact with the allergens known through chemical testing as well as under the influence of certain electrical frequencies.

Figure 3.1 shows the basis of Smith's research, **initially using homeopathically potentized dilutions of the allergens**:

Gradually increasing the potency shows that not only the allergens themselves, but also their **homeopathically potentized dilutions, cause reactions well into the intangible area of high potencies**. Here, too, the phenomenon observed by Miller reoccured: When gradually increasing the potency, among potency levels causing the expected negative effects (allergies), there were also potency levels that clearly showed neutralizing

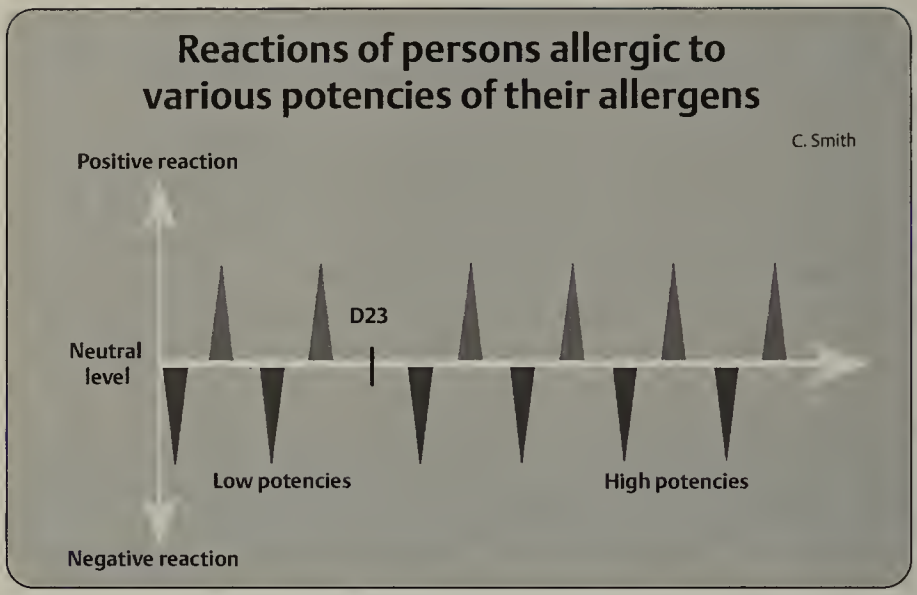

Fig. 3.1 Research by C. Smith with hyperergic patients using homeopathic potencies of their allergens (schematic).

effects. Neutralizing potencies are reproducible in an individual patient. However, they are unique to each patient.

Figure 3.2 illustrates experiences resulting from testing **electrical hypersensitivity**. The tests were conducted with a simple sinus oscillator that enabled the generation of any desired coherent frequencies. The patient was located at a distance of several meters from the oscillator. The frequencies were sent via a short antenna without touching the patient. Gradually increasing the frequency resulted in the same behavior as seen in the experiment using homeopathic potencies of an allergenic substance: specific (and in individual cases reproducible) frequencies causing the range of typical allergic reactions in the patient. However, they were interspersed with neutralizing frequencies that eliminate allergic reactions within a few seconds.

Monro and co-workers originally discovered that a neutralizing dilution of an allergen containing information is also effective when the patient simply holds an ampoule of the same dilution in his/her hand. As surprising as this may sound, this phenomenon was also valid for experiments using exclusively electrical frequencies.

Smith and his team experimented with water or water-based solutions (e. g., saline solution). Attached to the oscillator via a coil was a glass ampoule containing this solution which was "charged" for 4 minutes with the

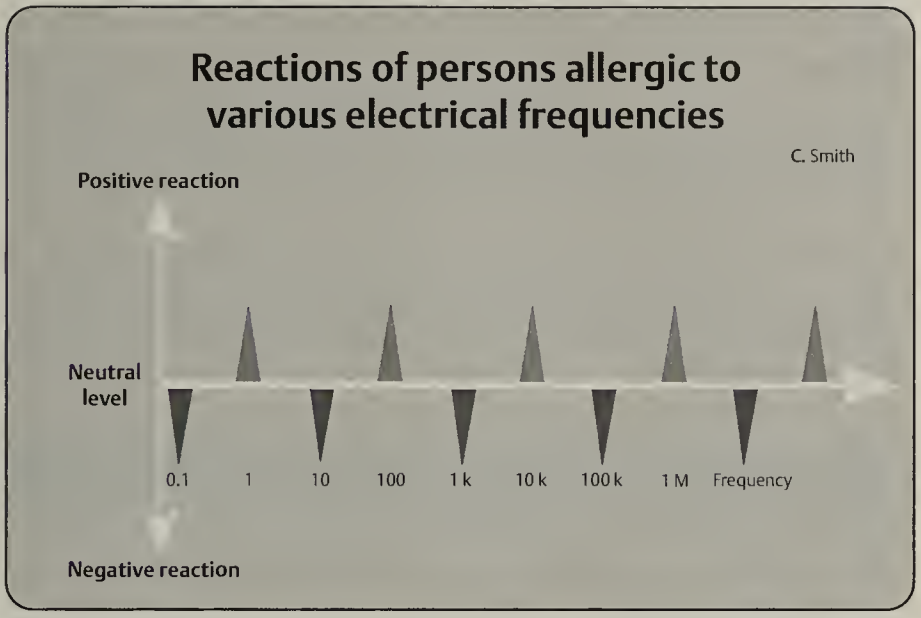

Fig. 3.2 Research by C. Smith with hyperergic patients using electrical frequencies (schematic).

corresponding neutralizing frequency. Subsequently, in contact with the patient, this solution proved just as effective as the frequency generated by the oscillator in the patient's room. This sensational research held important results for medicine. All experiments quoted here have been conducted by Salford University according to strict scientific criteria. They have been documented by video, etc. and the results published in scientific literature. Given these new parameters, the response of the scientific community was surprisingly uneventful. Findings that do not fit into the familiar paradigm are initially doubted and often ignored, let alone discussed.

What basic knowledge do the results of C. Smith's experiments convey to us?

1. Proof of the effectiveness of homeopathic high potencies also in the intangible area (beyond D23 = Loschmidt's number).
2. Proof of effectiveness of electrical frequencies in a living organism.
3. Proof that water has a memory function for electrical frequencies.
4. Proof of a component of allergy defined by physics, as all aforementioned phenomena are only explicable by physical mechanisms.

This presents two apparently opposing statements on the allergy phenomenon:

- On the one hand, the irrefutable findings of classical scientific allergology with its clear and provable **biochemical immunological definition.**
- On the other hand, the aforementioned results obtained by Smith that are only explicable within the framework of **physical information!**

This apparent contradiction is resolved when we apply the previously instituted thought modality of two distinctly separated functional levels (Fig. 1.1). Let us remember that basically everything that functions in our organism on the material level is regulated by the codified information in the informational level.

The superior informational level (regulatory level) controls the impulse that begins and regulates processes on the material level.

If we apply this fundamental law to the arena of allergies, it seems that within the frequency pattern of a particular living being there is some type of biophysical "**imprint**": a fixed information that registers the specific frequency spectrum of a substance as an allergen. Its presence and activation are the prerequisites for allergic reactions to take place in the body.

This biophysical imprint may be caused by repeated contact with a substance irritating the organism in one way or another. Not everybody is susceptible to developing allergy imprints. This ability seems partially due to a certain genetic predisposition.

Once formed, the allergy imprint remains in place. It is inactive unless it comes into contact with the allergen. Activated by the specific information that characterizes its imprint, it triggers the allergic reaction via impulses using the known mechanisms, i. e. antibody formation, mast cell sensitization, release of histamine, etc.

Typical for this kind of "allergy imprint" is not only the specificity—it is unique to a particular range of frequency information—but also the ability to manipulate it. Moreover, it can be treated with biophysical means. That is to say, by applying suitable information or techniques it can be attenuated and/or completely eliminated.

None other than the allergen's biophysical frequency pattern (= physics codification) is the "suitable information" for the "allergy imprint." Employing this specific signal and suitable implementation, it is possible to "register" this imprint, that is, to determine its presence, for example by means of the allergen resonance test and/or influence it therapeutically.

The ideas outlined here cannot (yet) be verified with data and do not claim correctness according to the current scientific point of view. They have, however, proven useful as a thought modality as they elucidate all phenomena occurring while treating a patient.

For biochemical immunological processes to take place on the material level, contact with an allergen is necessary to activate the allergy imprint.

Using the known mechanism, these biochemical immunological processes now initiate an allergic reaction. The patient shows symptoms such as irritated skin and mucous membrane, itching and edema, etc.

When the patient is episodically exposed to the allergen ("acute allergy" model, see Classification of Allergies, p. 49), the allergic reaction will subside. It will subsequently reappear upon renewed contact with the allergen.

Being continuously or frequently exposed to the allergen will result in chronic allergic stress that may eventually influence the entire organism. The allergic reaction turns into an **allergic disease** that can become increasingly independent, with the connection to the allergen becoming less and less obvious (e. g. neurodermatitis, chronic bronchial asthma). We will describe these interrelations in more detail in Chronic Forms of Allergies, page 50.

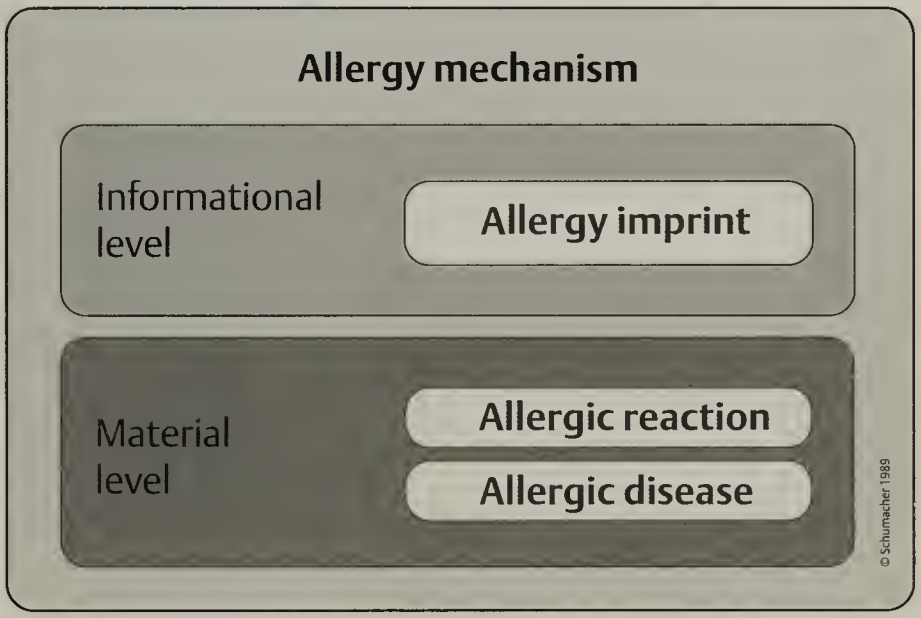

Fig. 3.3 Simplified thought modality to explain physical allergy mechanisms (see text).

The schematic illustration in Figure 3.3 is meant to once again demonstrate the hierarchy of the "levels." It shows that in all cases the informational level needs to emit an impulse for corresponding reactions to take place on the material level.

4 Symptoms of Allergic Reactions

Allergic reactions can manifest in so many ways throughout the body that we need to consider an allergy when looking at almost every medical symptom!

The most common symptoms are listed in the table below:

Most Common Symptoms of Allergic Reactions
General symptoms: Fatigue, decreased performance, feeling cold, vertigo
Cutaneous symptoms: Exanthema (maculate, popular, urticarial, etc.) Quincke's edema, itching, neurodermatitis—all severities
Irritation of the mucous membrane: Rhinitis, sneeze impulse, conjunctivitis, itchy eyes, cough, bronchial asthma
Gastrointestinal symptoms: Feeling of repletion, gastritis, stomatitis, diarrhea, meteorism, Roemheld's syndrome, colitis in various forms
Heart and circulatory symptoms: Variations in blood pressure, syncope, tachycardia, extrasystole
Bladder symptoms: Polyuria, dysuria, irritable bladder, susceptibility to urinary tract infections
Muscles, joints: Sore muscles, rheumatic pain
Psychological symptoms: Depression, restlessness, confusion, feeling dazed, anxiety and panic attacks, aggressiveness, hyperactivity in children
Headaches and migraines
Weight loss and gain
Anaphylactic shock

The location, intensity, and time of appearance of allergic symptoms depend on various factors:

Allergy symptomatology depends on:
- Genetic factors.
- Type and quantity of antigens.
- Patient's level of sensitization.
- Organism's current state of health.

Usually the prerequisite is a **genetic predisposition**. The **ability** to create an allergy is inherited, **not** the type of allergy or the substance that causes it.

The **allergen potency** of a trigger substance varies. Aggressive **allergens** are substances that easily cause sensitivities (e. g., grass pollen, cat hair, strawberries). Therefore the clinical symptomatology caused by these substances occurs frequently.

Allergic reactions vary depending on the general state of the organism.

Any **somatic** stress (other illnesses, focal infections, toxic or geopathic stressors) can intensify a reaction.

Particularly important is any kind of **psychological stress.** Fear, grief, excitement, being overtaxed at work or school, etc. can cause the onset of or intensify allergic symptoms. On the contrary, these symptoms may improve considerably or disappear completely in a relaxed, harmonious situation.

Most people with allergies have particular "target organs" that tend to manifest allergic reactions (specifically skin, bronchials, intestinal mucosa).

5 Classification of Allergies

Classification by Type According to Coombs and Gell

Most textbooks used in clinical allergology are based on the type classification established by Coombs and Gell in 1963 (Fig. 5.1).

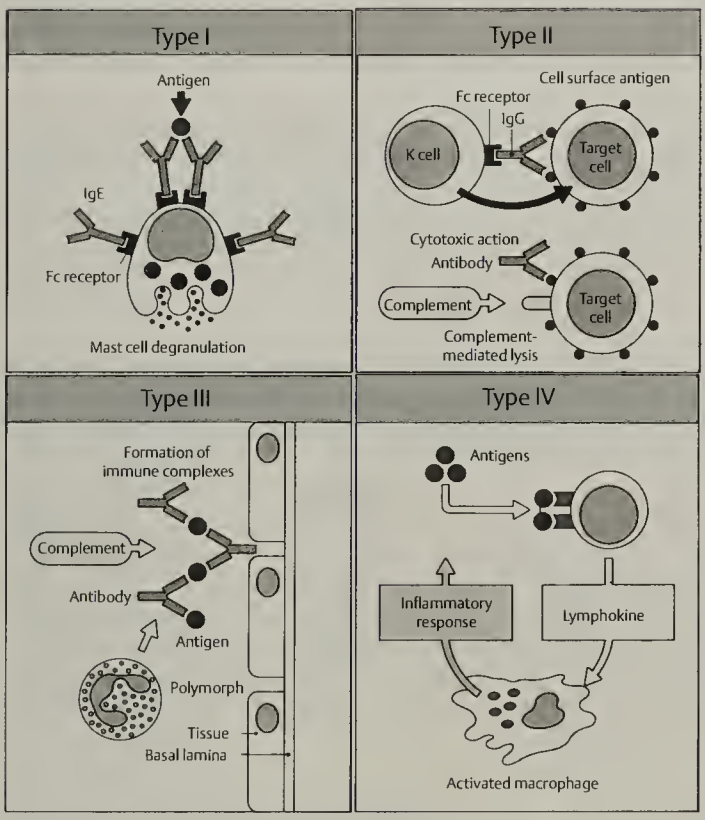

Fig. 5.1 Immunological mechanisms of the four most important allergy types. Illustration according to Roitt, Brostoff, and Male: *Kurzes Lehrbuch der Immunologie* (Short Treatise of Immunology), 1987.

4 Types of allergies according to Coombs and Gell:
Type I: Acute allergic reaction (anaphylactic type)
Type II: Cytotoxic type
Type III: Immune complex reaction
Type IV: Delayed reaction mediated by cells

The classification by pathomechanisms systematizes the multitude of allergic diseases. It has been applied for more than three decades and has proven scientifically instructive:

Type I—acute allergic reaction (anaphylactic type): IgE-mediated degranulation of mast cells and consequent release of mediators. The classical allergy symptoms such as hay fever, urticaria, Quincke's edema, allergic asthma, etc. (Fig. 5.2) fall into this category.

Type II—cytotoxic type: Antibodies, directed toward antigens on the surface of specific cells, cause cell destruction. This category includes blood type incompatibilities, hemolytic anemia, allergic agranulocytosis or thrombocytopenia, etc.

Type III—immune complex reaction: Circulating immune complexes activate the complement system as well as neutrophilic granulocytes and thrombocytes. An immediate reaction leads to "immune complex anaphylaxis," a delayed reaction to "serum sickness," and similar types of reactions.

Type IV—reaction mediated by cells: This group contains immune reactions that are mediated by sensitized T-lymphocytes. Among these allergies are contact eczema and a number of drug eruptions.

(Recently two more types have been suggested: Type V, certain granulomatous reactions, for example after injections; Type VI, "stimulatory hy-

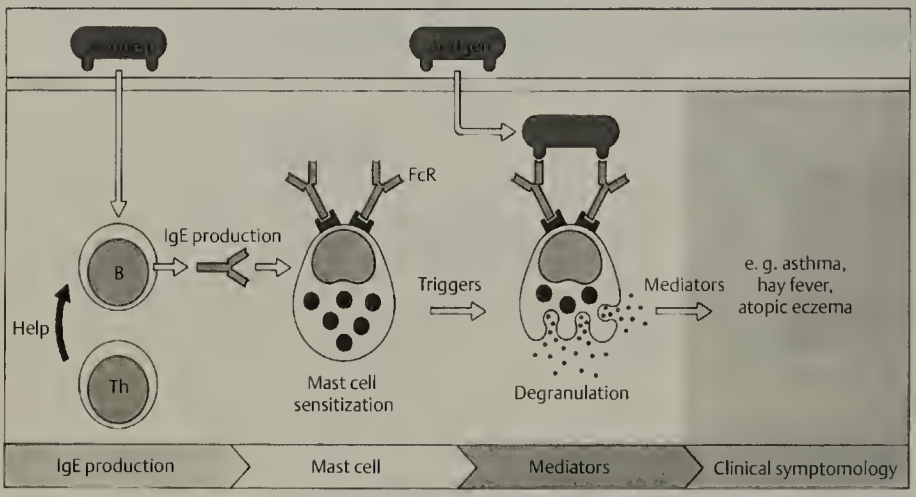

Fig. 5.2 Immunological mechanism of a Type I allergy (according to Roitt, Brostoff, and Male: *Kurzes Lehrbuch der Immunologie* (Short Treatise of Immunology), 1987.

persensitivity", for example as seen in autoimmune diseases of the thyroid. Both types may only be relevant for the highly specialized clinical field.)

Type I reactions are by far the most important for the medical practitioner. Separated into two big groups, they are discussed in the following chapters.

Over the course of the last few years, we have gained many new perspectives regarding the subject of allergies. Consequently, we now know that the type and frequency of contact with the allergen, in the case of Type I allergies, plays a more significant role than previously assumed. That is why we distinguish between **acute**, more or less episodic and superficially occurring allergies, and **chronic** allergy forms that profoundly affect the body for extended periods of time. This has proven to be practical and didactically fruitful.

Acute Forms of Allergies

Acute allergies are the domain of clinical allergology. They can usually be diagnosed by means of traditional testing methods. Their interrelations can be seen clearly.

Acute allergies are understood to be allergic reactions to substances to which sensitization has occurred. The body is only **occasionally or temporarily** exposed to those substances.

Among the acute allergies are most of the **inhalation allergies** such as pollinosis and allergy to animal epithelia, chemicals, fragrances etc. Also contained in this group are acute reactions to the **ingestion of allergens** (e. g., macular, papular, urticarial exanthema and edemic reactions after ingesting strawberries, peaches, pharmaceuticals). Figure 5.3 shows a typical example from the medical practice. In the second part of the book we will discuss the individual clinical symptomatology in more detail.

Fig. 5.3 Example demonstrating acute drug eruption: Acute occurrence of symmetrical, urticarial exanthema after ingesting Ospen syrup. Primarily affected are the extremities.

Chronic ("Central") Forms of Allergies

We are no longer talking about acute reactions to certain allergens, but about the long-term effects of allergies to substances that the body is more or less continuously exposed to.

People with a genetic predisposition often develop chronic allergies in their early childhood. They are caused by sensitization to a **staple food that is frequently ingested (usually daily), or by a substance continuously present in the body** (e. g., candida in the case of chronic intestinal mycosis, mercury in people with amalgam fillings).

Frequent or continuous contact with the allergen **masks** the allergy. An immediate connection between symptoms and allergen is often indiscernible.

Cow's milk is usually the first foreign protein a baby, in our culture, will be exposed to. (All industrially manufactured baby food, with the exception of special diet foods, is made with cow's milk.)

Wheat is second. As flour, semolina, flakes, etc., it is also an ingredient in many baby foods. By the second year of life it has become a substance that is ingested daily in the form of bread, pastries, pasta, etc.

Due to primarily positive test results, **chicken** eggs are often accused of being an allergy-provoking antigen. In our experience they are responsible for triggering central allergies only in exceptional cases. The informative statistics by Gerrard, Hattewig and co-workers were previously mentioned. They confirm our observations that many people have built up specific antibodies to chicken egg protein (resulting in positive tests), though only a small number display actual relevant allergic symptoms.

Interestingly, **meat**—of whatever kind—does not play a role as a central allergen. Mackarness, one of the few physicians in the US recognizing and accepting these correlations, believes that human beings were initially designed to be **meat eaters** and were accustomed to a diet of primarily fatty meats for hundreds of thousand of years. His "**stone-age diet**" produced sometimes surprising results with chronic food allergies.

Regardless of whether human beings were originally meat eaters or not, which is still periodically the subject of debate, it seems important to note that today **cow's milk** and **wheat** are by far the most important triggers for central allergies. They are virtually the only foods that we have all ingested **daily** since early childhood. Accordingly, the reactions they cause occur frequently although they are usually not easily recognizable as **milk** or **wheat allergies**.

It is one phenomenon of our present times that scientific medicine still ignores the actual interrelations despite tremendous investment into major and extensive research for neurodermatitis, colitis, etc. Doubtlessly, the main reason for this is the unreliability of traditional test methods with regards to food allergies. A negative test result seems to be enough to prohibit any further deliberations as to whether or not it might be an allergy.

Why are the interrelations so difficult to recognize in the case of chronic allergies? The one term central to this issue is **masking**.

The American physician, Herbert Rinkel recognized this phenomenon and, very fittingly, coined this term after having dramatically experienced it himself. One of his students, Richard MacKarness, tellingly describes Rinkel's experiences in his book *Allergie gegen Nahrungsmittel und Chemikalien* (Allergies to Foods and Chemicals) (1986).

As a medical student, Rinkel had little money. Over the course of several years, his main diet consisted of eggs, which his father, a Kansas farmer, sent him in large quantities to help save money. Rinkel became increasingly unwell. He developed an unusually heavy nasal catarrh with unbelievable amounts of mucus that ran from his nostrils. Sometimes, Rinkel says, "*it even went all the way to the floor.*"

After reading a publication by Rowe he thought that his chronic symptoms may be caused by a food allergy. Eggs immediately came to mind. He ate six eggs as quickly as possible and expected an acute reaction to confirm his theory that he was sensitive to eggs. Nothing happened. On the contrary, he felt better than before. He gave up. For a while Rinkel forgot about his egg allergy theory. Four years later, after some in-depth study of allergies, he tried a different approach. He eliminated eggs from his diet. Several days later he felt significantly better.

Five days after he stopped eating eggs it was his birthday. His wife baked him the usual birthday cake. Ten minutes after eating one piece, Rinkel became unconscious and did not recover for several minutes. He surmised that, "*he must have been extraordinarily sensitive to some ingredient in the cake.*" Questioning his wife, he was told that she used three eggs in the cake batter. He concluded that he had become hypersensitive to eggs after not having had any for five days. Therefore, even the tiny amount of egg contained in the small piece of cake he had eaten caused the severe allergic reaction.

Fascinated by this idea, Rinkel repeated the experiment. On the fifth day, after having abstained from eggs, he ate a small amount of egg and suffered another severe allergic reaction! Following that episode, he developed a test method for masked food allergies. He wanted to publish his experiences in the Annals of Allergy, but was perfunctorily rejected. Upset about the arrogance of the established scientific community, he decided to develop the test method in great detail, only then introducing it to the public.

For 8 years he conducted 20 000 individual food tests on his patients and published his absolutely convincing results (Rinkel 1944). That was 60 years ago (!)—allopathic medicine still knows nothing of them!

Rinkel defines masking as follows: "*If someone eats a certain kind of food daily or almost daily he/she can be allergic to it without ever suspecting that particular food to be the cause of one's symptoms. It is common that the person feels better after having eaten the food than before its ingestion.*"

Masking of a food allergy:
The symptoms caused by the allergen **diminish or disappear** if the patient ingests the same allergen again within a certain period of time (commonly 1 to 3 days).

Rinkel's test was based on the targeted elimination of certain types of food from the diet. This method is also called the elimination diet. Still practiced today, it has a two-fold effect:

1. Allergy symptoms improve (often after initial worsening).
2. After several days, at the most, the actual interrelations become evident; the allergy has been de-masked.

De-masking of a food allergy:
An allergen, in the form of a type of food, **regularly** ingested will cause an acute allergic reaction **if it had previously been completely eliminated from the diet for 3 to 4 days** (Rinkel).

Thus neither the patient nor the physician recognizes true chronic allergies as food allergies. (Because of the deep-reaching effects, we also like to use the term **central allergies**.)

Scientific literature still cites detailed anamnesis of the patient as the main support for diagnosis of food allergies (50 to 80 % depending on the author). This shows clearly that even if the patient is questioned in the greatest detail, only those acute allergies that the patient is aware of can be recorded. Due to the masking effect, the much more significant chronic–central allergies remain hidden until someone—physician or patient—(consciously or not) begins to de-mask the allergy.

Chronic allergies play an important role for the individual patient as well as for medicine as a whole. Significant, commonly occurring illnesses such as **neurodermatitis, chronic "endogenous" bronchial asthma, and ulcerative colitis** are unquestionably caused by the chronic allergic mechanisms mentioned here.

We do not state this as an allegation based upon hypotheses. Unequivocal evidence can be found in (by now) several hundred case studies of chronically ill patients, some of whom suffer severely.

We will discuss the interrelations in more detail when we reach the individual clinical symptomatologies. Our statements are quite contrary to current expert opinion. Due to consistently successful therapy, however, we are in the fortunate position to be able to prove the validity of our claims.

As a preview of the more detailed discussion in Part II of this book about the various allergic clinical symptomatology, Figures 5.4 and 5.5 are an example of a severe generalized neurodermatitis continuing since early infancy. Diagnosed as a chronic allergy to cow's milk protein, it was successfully treated by completely avoiding cow's milk. It was ultimately eliminated by means of bioresonance therapy. The child completely recovered and has been symptom free for more than 4 years.

Fig. 5.4 Cow's milk neurodermatitis: 16-month-old child with generalized neurodermatitis since infancy caused by a chronic allergy to cow's milk protein.

Fig. 5.5 Patient depicted in Figure 5.4, completely healed.

We should therefore note: Most cases of neurodermatitis, chronic bronchial asthma, and ulcerative colitis are not "an untreatable condition that must be endured" as many physicians tell their patients over and over again. These maladies are **allergic diseases that can definitely be cured!**

This goal, to cure a disease that can barely be influenced and whose symptoms, at best, have been treated, requires awareness and patience from both physician and patient alike. The certainty of pursuing a path that promises success and makes sense is almost always a sufficient motivator to deal with all difficulties and setbacks.

Let me specify once again: chronic allergies are allergic reactions to substances that are consistently ingested via food or that the body is continuously exposed to. They occur primarily in people with an atopic disposition and lead to characteristic clinical reactions:

- on the **skin**: chronic eczema, atopic dermatitis, neurodermatitis;
- within the **bronchials**: relapsing spastic bronchitis, bronchial asthma;
- within the **intestine**: relapsing diarrhea, enterocolitis, chronic colitis.

Constant contact with the allergen exposes the patient to heavy **continuous stress.** Due to the masking effect, the type and extent of the symptoms do not seem to relate to the ingestion of the allergen. For example, they do not worsen when a person allergic to milk eats a lot of cheese or curd cheese or somebody allergic to wheat eats primarily pastries while on his/her vacation.

The severity of the symptoms largely depends on how successfully the organism can compensate for the allergic continuous stress. Therefore any **additional stressors**, be they physical or psychological (illnesses in the broadest sense of the word, such as toxic, geopathic, or focal stressors and particularly psychological tension and conflicts) may trigger a change for the worse.

Of vital importance is the condition of the excretory organs, particularly the **intestine**, in patients with chronic allergies. In many cases **intestinal fungi** (usually unnoticed by the patient) adds additional stress.

On the other hand, many patients notice that their symptoms often significantly improve in times of general **relaxation**, for example while on vacation. Any relief to the organism may pacify and improve the severity and course of the symptoms. **True healing, however, is only possible if the cause of the illness—the allergy—is eliminated!**

This requires that the **allergen** (as previously mentioned, often cow's milk protein or wheat, or both) is recognized as such and completely eliminated from the diet. This will **de-mask** the allergy after 4 to 5 days at the most!

Not until that time will the actual allergy interrelations be recognized and proven. After this day the smallest mistake, even the minutest amount of allergen intake, leads to a clear allergic reaction (see the striking example H. Rinkel's birthday cake revealed).

We have coined the term **allergic disease** and use it for the mechanisms of chronic allergies whose symptoms tend to become gradually independent of the allergen. In contrast to this is the **allergic reaction**, which is completely dependent upon the allergen that produces an acute reaction (see Fig. 3.2).

It is the allergic disease that can determine the fate of a patient if it is not recognized as a manifestation of a chronic allergy and is, consequently, not treated appropriately.

Besides the classic clinical symptomatology for neurodermatitis, asthma, and colitis, there are numerous **oligosymptomatic or asymptomatic forms** of chronic allergic stressors that are revealed only through testing.

Even though the patient is often unaware of their presence, they may be the basis for the development of further—**acute**—forms of allergies. Experience proves that the occurrence of most **multiple allergies in people** (to different substances such as pollen, food, food additives, etc.) is based on a chronic allergy, appearing completely or partially without symptoms, which was often acquired during early childhood. Exposing and treating this central mechanism often brings about a significant change for the patient. Some acute allergies disappear on their own while others are easily eliminated using short-term therapy.

The field of chronic allergies automatically overlaps, to a great degree, with the theses advocated by "clinical ecology." Without meaningful test methods it is almost impossible to distinguish a true allergy from a quantitatively dependent pseudo-allergic reaction or a mere intolerance.

Pseudo-allergic Reactions

Classical allergology defines a **true allergy** as a process taking place in the immune system mediated by specific antibodies. Physical medicine considers the (superior) aspect of a reaction to a substance-specific "code" for which an allergy imprint was created on the patient's informational level.

Intolerance reactions have become commonly known as **pseudo-allergies** in scientific allergology jargon. "*Their clinical symptomatology is very similar to allergic reactions. However, there is no evidence for immunological mechanisms*" (Dukor et al., Ring).

As previously discussed, immunological diagnostic methodologies are somewhat unreliable, particularly with regard to food allergies. Therefore, this definition appears to us to be of little use, at least in daily practice. We use the term pseudo-allergy in a different way; for us it denotes **quantitatively dependent intolerance reactions**.

A true allergy is a **qualitative** phenomenon. That is to say, the allergic reaction is caused by contact with a tiny amount, possibly just the intangible frequency information of the allergen.

We use the term pseudo-allergic reaction for intolerance reactions that clearly show a **quantitative** phenomenon where the reaction usually occurs after exposure to a certain amount of the allergen. This frequently applies to chemical food additives that have been legally integrated into food products in unbelievable amounts.

In contrast to a true allergy, which is an immunological qualitative phenomenon, a pseudo-allergy is a toxic, **quantitative** phenomenon, which needs to reach a certain **level** before displaying any allergic symptoms.

Frequently, chemical food additives cause the reactions.

Criteria for a pseudo-allergic reaction to appear are:

1. The patient's individual sensitivity.
2. The **sum total of the substance**, which is simultaneously ingested through **various foods** of varying chemical compositions (e. g., azo dyes, benzoates, phosphate, PHB ester, etc.).

See Figure 5.6 for a typical example: For many months an itching, macular, partially urticarial exanthema appeared on the inside of the right thigh of a 6-year old boy. It was always in the same place and disappeared after a few days. After extensive questioning, it turned out that the rash usually appeared after the boy had visited his grandmother. Once it also appeared after a children's birthday party.

Fig. 5.6 Macular urticarial exanthema on the inside of the right thigh, considered to be a pseudo-allergic reaction (quantity dependent) to the red coloring agent E122 (carmoisine). See text.

An allergy test showed an allergy to the red coloring agent E122 (carmoisine), commonly contained in numerous red-colored fruit juices, jams, and sweets.

After checking with the grandmother we found the typical summation mechanism: the child ate lots of jam sandwiches or cake during his visits. The same red-colored jam was the common ingredient. He also drank a particular kind of red cherry juice. With regard to the children's party, we were also able to trace back the accumulation of red coloring agents. There was lots of raspberry juice, jelly babies, and other red-colored sweets.

Drinking an occasional glass of the same kind of raspberry juice (that verifiably contained E122) produced no reaction. Typically it seems that a certain threshold needs to be reached to trigger this type of allergic reaction.

As many food additives can also cause **true allergic reaction**s, the moment of transition from pseudo to true allergy is difficult to gauge. In that case they clearly show characteristics of a **qualitative** reaction, that is to say, the **ingested quantity is irrelevant** in terms of triggering a reaction.

Intolerance Reactions

Individual intolerances to food and/or chemical substances occur frequently. We do not want to contest their clinical relevance. Rather it seems necessary to create a clear delineation of the true allergy phenomena. We already discussed this issue in the section dealing with defining the term allergy and emphasizing that misunderstandings between the advocates of different theories cannot be avoided unless all participants share the same definition.

We are still a long way from this ideal. The most important opponents, classical allergology and "clinical ecology," still speak very different languages. At least scientific allergology was willing to summarize the numerous, fundamentally subjective, conditions caused by foods under the heading "clinical ecology syndrome" (Ring). Examples of known, non-immunological causes of intolerances are insufficient digestion of foods due to a **lack of enzymes** and the natural amount of **histamine** in food, possibly increased by storage, ageing and/or histamine-releasing substances. Some foods contain astonishingly high histamine levels which may easily cause symptoms that are commonly associated with allergic mechanisms. (100 g of old cheese may contain up to 85 mg of histamine, and 100 g of tuna fish up to 400 mg!)

Regardless of these comprehensible and explicable causes of negative effects foods may have on an organism, most people develop varying degrees

of intolerances to numerous foods or food combinations that will manifest in a variety of ways over the course of their lives.

These **intolerance reactions** (to use a neutral term) often show distinct parallels to the general adaptation syndrome postulated by Selye. For the first time in 1954, T. Randolph, the actual founder of clinical ecology, connected the three stages of the adaptation syndrome by Selye with Rinkel's previously mentioned masking phenomenon.

Selye's three stages of adaptation can also be observed in the case of food intolerances:

Alarm reaction → Stage of adaptation → Stage of exhaustion

Masking corresponds to the second stage where the body adapts to the stressors. Somebody at that stage may frequently have cravings for a particular substance, which is why parallels are drawn to the issue of addiction.

We do not want to interfere in related discussions, nor question the theorems of clinical ecology. However, we are convinced that a clear distinction between the terms allergy and intolerance is required to aid in the understanding of the various pathomechanisms.

The area of **diagnostics**, determining the substances a patient cannot tolerate, is one of the main issues clinical ecology has always had to deal with. Originally, the standard diagnosis consisted of an elimination diet with subsequent exposure to the antigen as Rinkel had developed based on his experiences ("challenge test"). By eliminating an intolerable substance, the patient regresses from the stage of adaptation (stage II according to Selye) to stage I (alarm reaction). De-masking, in the form of an immediate reaction, takes place when the patient ingests the substance again. Unfortunately this method is cumbersome and time consuming particularly when dealing with more than one intolerable substance.

The "pulse test" initiated by A. F. Coca (1958) improved diagnostic possibilities to some extent. He observed that food intolerances are regularly accompanied by a quickening of the pulse. A few drops of a solution of a suspected type of food are placed sublingually and subsequently the patient's pulse is taken. A noticeable quickening of the pulse is an indication of intolerance.

Methodologies employing physics-based information such as the different techniques of kinesiology, electro-acupuncture (EAV, BfD, Vega test) and auriculomedicine (VAS) brought about a significant improvement in diagnostic techniques. They were instrumental in the rapid development of clinical ecology, particularly in Europe.

Every one of these methodologies requires a certain adjustment and practice. However, as many substances can be tested in a relatively short period of time, they enable the medical practitioner to test much more efficiently. Their diagnostic "sensitivity" is certainly advantageous, yet they also run the risk of returning too many "positive" test results that may be completely irrelevant for the patient.

The symptomatology of intolerance reactions differs from true allergies mainly in that it affects the general state of well-being. Fatigue and exhaustion (even when rested), restlessness, lack of concentration, anxiety, depression, etc. are at the forefront. Of course, combinations with true allergies (hay fever, asthma, skin rashes to certain substances, etc.) are possible. They are frequently found to occur in practice.

Clearly separating these terms, as important as it may seem in theory, is without doubt immaterial when seen from the patient's point of view. If a patient is suffering, it is irrelevant to him/her whether the cause is a true allergy in the traditional clinical sense or an intolerance or hypersensitivity. What is crucial, however, is that a specific substance is compromising his/her health and how to obtain relief from pain.

We define intolerance reactions as intolerance to foods and/or chemical substances that have gradually developed over the course of a life.

Immunological mechanisms cannot be proven; the symptoms primarily affect the general state of well-being.

Combinations with true allergies (e. g., hay fever, allergic asthma) frequently occur, but are not mandatory.

Masking phenomena are common; correlations to addiction mechanisms are occasionally recognizable.

Contact Allergies

Recent experience has shown that contact allergies are subject to their own laws. Therefore, they need to be mentioned specifically within the context of the biophysical point of view.

According to the classification by Coombs and Gell, introduced in 1963, reactions occurring after 12 or more hours were grouped together as Type IV (delayed-type allergy).

The important difference to other forms of allergies is evidently not the time of reaction, but the immunological mechanism that takes place exclusively on the cellular level with contact allergies.

(When in contact with the allergen, mediated by antigen-presenting cells [APCs], sensitized T-lymphocytes release lymphokines that cause inflammatory reactions by activating macrophages. See Fig. 5.7.)

There is neither positive proof of antibodies in the blood nor, in our experience, evidence of formation of a **physical allergy imprint**. In any case, the regular inverted frequency therapy modality will have no effect on these types of allergies.

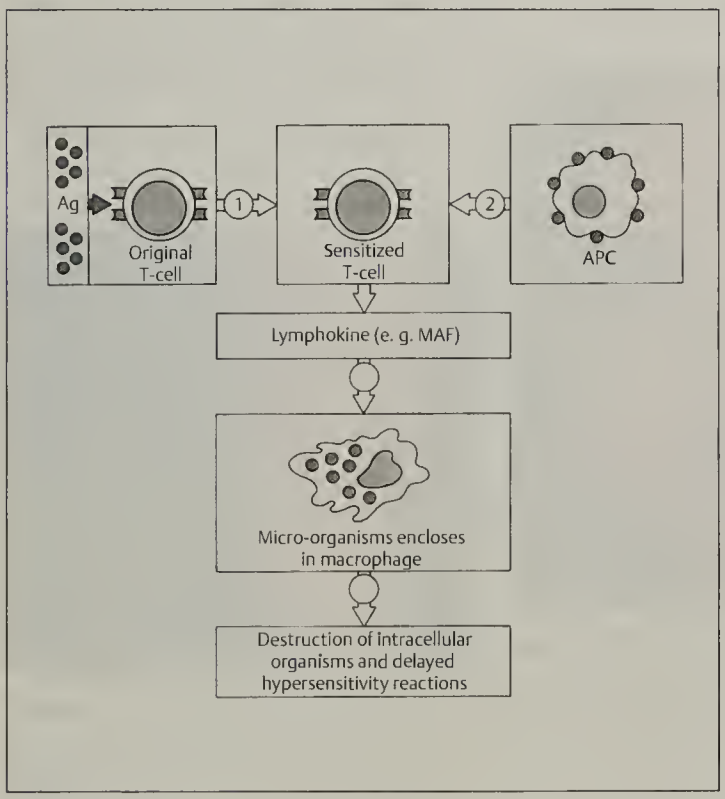

Fig. 5.7 Immunological mechanisms for a Type IV allergy. (According to Roitt, Brostoff, and Male: *Kurzes Lehrbuch der Immunologie* (Short Treatise of Immunology) 1987.

Type: Cellular allergy
When in contact with antigen-presenting cells (APCs), sensitized T-lymphocytes release lymphokines that cause inflammatory reactions by activating macrophages.

Fig. 5.**8** Chronic localized focal eczema, retroauricular demonstrating a contact allergy to nickel.

Fig. 5.**9** Allergic reaction due to contact with cat hair; residual allergy after successful therapy of a Type I allergy with severe asthmatic reactions. The asthmatic reactions to cat hair disappeared completely after therapy. Remaining is a Type IV element concurrent with itching rash after intensive contact with the cat.

Fig. 5.**10** Remaining contact allergy after eliminating a Type I allergy to chicken egg protein. The generalized allergic reactions (generalized exanthema and asthmatic reaction), which occurred regularly after ingesting chicken egg protein, have since disappeared. A Type IV element remains, concurrent with a localized reaction of the mucous membrane (swelling of mouth) after contact with unprocessed egg.

Fig. 5.**11** Positive patch test to unpasturized cow's milk: child with contact allergy to cow's milk only. Skin or mucous membrane reactions only occur in direct contact with unpasturized cow's milk. Generalized reactions are completely absent. Cow's milk in processed form (e. g., in cooked or baked goods) causes no reaction.

The classical manifestation of cellular hypersensitivity is **allergic contact eczema**. It is most commonly triggered by metals (nickel, chromium, cobalt), rubber additives, cosmetics, disinfectants, preservatives and pharmaceuticals in topical preparations, etc. as well as phytogenic substances in direct contact with the skin (Fig. 5.8 shows a typical example).

Besides the exogenous allergic forms that are sensitized and triggered by epidermal contact, there also seem to be **endogenous forms** of this allergy type, sensitized and triggered by systemic contact with the antigen.

Combinations with Type I allergies occur and seem to be more common than previously assumed. At times, Type IV elements can be found specifically in atopics (people with inherited stressors, plus one or more allergies of Type I). If the allergies are not recognized and diagnosed as such, they may cause a great deal of confusion for both physician and patient. They are not recognizable unless an **apparent contact reaction persists** after successful biophysical therapy. Let us take as an example a patient who had asthmatic reactions to cats. His asthma disappeared completely after allergy therapy, but an itching rash appeared after intensive contact with the cat (Fig. 5.9).

Interesting, yet rare, are **contact allergies in the case of food allergies**. We know several patients who had cow's milk neurodermatitis. After strictly avoiding milk and undergoing subsequent allergy treatment, the neurodermatitis disappeared completely. However, if the skin or mucous membrane came into contact with undiluted milk, swelling and redness—even symptoms of Quincke's edema—occurred. An allergy to chicken egg protein shows similar symptoms. After biophysical treatment patients tolerate all foods containing eggs in processed form; however, massive allergic skin or mucous membrane reactions occur when they come into contact with unprocessed egg (Fig. 5.10).

An allergen resonance test conducted post therapy displays negative results for most patients. Epicutaneous tests, a patch test, or simply rubbing the substance on the skin, however, will show positive test results (Fig. 5.11).

Type IV allergies do not register during physical allergy therapy modalities (program 999 of the BICOM device) commonly used to date.

In parallel, the new methods, which include amplified allergen information, have brought about a change in this area (see later in this book). When applied correctly, even contact allergies can often be treated successfully.

A contact allergy is purely a substance-based phenomenon occurring exclusively on the cellular level.

It can be diagnosed by a reaction obtained from direct contact of the substance on the skin or mucous membrane (epicutaneous test); tests on the informational level (allergen resonance test, EAV test, etc.) yield uncertain results.

Combinations with Type I allergies occur (residual symptoms remain after treating a Type I allergy).

Therapy is possible. Any contact with the allergen must be avoided (that is to say, no contact with the actual substance; it does not apply to allergen exposure on the informational level!) or bioresonance therapy with charged allergen information.

6 Biophysical Allergy Diagnosis

Significance of the Diagnosis for Biophysical Allergy Therapy

Every allergy treatment (except the strict suppression of symptoms) is dependent on an exact diagnosis of the allergen. This applies to essentially every type of hypersensitivity treatment. Most importantly it applies to the biophysical method. The specific physics codification of the allergen allows for the influence and elimination of the corresponding allergy imprint.

The **allergy imprint** (a theoretical thought modality to explain biophysical aspects of the allergy phenomenon) was defined as a biophysical imprint, a type of fixed information wherein the specific frequency spectrum of a particular substance is registered as an allergen. This particular imprint must be present and activated for allergic mechanisms to take place in the body.

Biophysical allergy diagnostics must be capable of determining all allergy imprints in the patient's informational system and measuring them in some way, in any case revealing them.

We already mentioned suitable diagnostic methodologies. Therefore, we will not presently discuss them in detail. Each tester should choose a method that he/she most relates to and that matches his/her abilities. Anyone proficient in several methodologies can double-check his/her own diagnosis.

The accuracy of the diagnosis, not the test method, is crucial for subsequent therapy success.

We prefer the allergen resonance test developed in recent years. Technically it is a simple procedure, easily learnable in a weekend seminar. The test has proven advantageous in practice. Developing and applying exactly these test methods provided many new and important findings, which are reflected in the treatment results. Proof of the correct diagnosis is automatically inherent in the principle of the biophysical treatment methodology—eliminating the allergy imprint using the allergen's inverted frequency pattern—as only the allergen itself makes this therapeutic success possible. This strictly specific physics codification is able to "call up" the respective allergy imprint and allow access to it. All other information passes by with-

out effect. Considering these findings, **each successfully biophysically treated case is proof of the accuracy of the diagnosis.**

Test Material

Developing physics-based test methodologies significantly expanded and improved the methods available to diagnose allergies. Industry-manufactured allergen preparations are no longer necessary. Alternatively, each substance can be used for testing as long as its specific frequency information—the physics codification—is available in some form.

Each test conducted at the physics level—irrespective of the methodology used—is fundamentally based on contrasting two systems that contain information and determining their relationship to each other. Results can be established by various means: a change in the strength of an indicator muscle (**kinesiological test methodology**); via vascular autonomic signals (VAS by Nogier); changes in electrical measurements using **electro-acupuncture** techniques (EAV, BfD, Vega test, etc.); or via frequency information of a "sensor element" (**allergen resonance test**). In each case the test substance must be available in a form suitable for the applied methodology. If a tester is properly trained, he/she is able to work very efficiently with any physics-based test methodology, meaning that many substances can be tested in a relatively short period of time. Appropriate **testing materials** are important in order to select equally appropriate substances from a multitude of substances. Any practitioner should have at his/her disposal a **collection of allergens** based on the requirements of his/her own practice. It should contain all possible allergens and be clearly organized to allow for quick testing.

Electro-acupuncture methodologies (Voll, Vega, BfD) require allergen preparations that are homeopathically **potentized** up to D5. Morell's treatment methodology uses **inverted information** in the MORA or BICOM device and requires non-potentized unadulterated substances for the test.

Most other physics-based test methodologies (the allergen resonance test included) test with the **original substance**. Therefore, allergens used for testing may not be potentized. (A proficient tester may successfully test up to a potency of D4. This, however, frequently leads to erroneous measurements.)

Based on our experiences in the practice and its requirements, we have developed specific **test sets** over the course of many years. Although originally intended for our own use, many colleagues have found them quite useful as well.

Presently available are five test sets containing 80 to 90 test substances each:

- The **foodstuffs** test set pertains to the major food groups and luxury foods.
- The **inhalation allergens** test set contains all major animal epithelia, bedding materials, fungi, and mites.
- The **food additives** test set contains chemical substances which, according to EU law, may be lawfully added. According to general experience, however, they very frequently cause allergic or pseudo-allergic reactions.
- The **pollen** test set contains approximately 90 pollen antigens to make a detailed diagnosis available and also to treat hay fever.
- In a test set called **identification test set** we combined pesticides, domestic and industrial toxins, carcinogens, etc. The book *Die Testsätze nach Dr. P. Schumacher* (Test Sets According to Dr. P. Schumacher) contains further information about the test sets that contain more than 400 test substances at this time.

However a personal allergen collection is set up, it is important to clearly organize the test substances. They must be stored appropriately. The above mentioned test sets contain individual ampoules sorted by groups in a foam template (Fig. 6.1). Anyone can set up their own allergen collection the

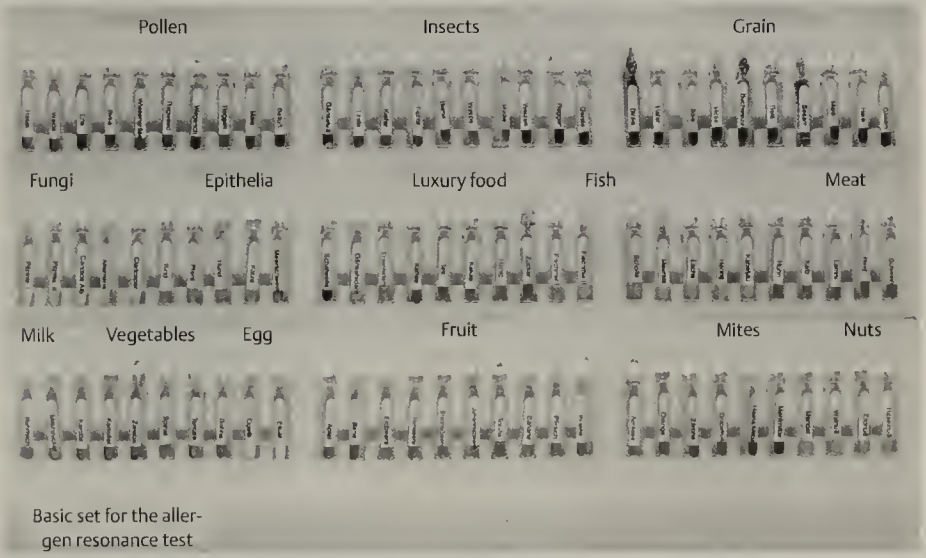

Fig. 6.1 Example of a test set for biophysical allergy testing.

Fig. 6.2 Selitest (Lichtenberg, Inc.): quick test system. Test ampoules (containing allergens) are structured in radial rows in a plate honeycomb. Tests can be conducted on the rows or on individual ampoules.

same way if they like this arrangement. We provide **empty test sets** for this purpose with the same template containing empty test ampoules.

The actual testing itself can be done with individual allergens. The appropriate test ampoules are placed individually into an **electro-acupuncture honeycomb**. A simple cable connects the honeycomb to the measuring device. A **rotating honeycomb plate** (e.g., Selitest, Lichtenberg, Inc., Fig. 6.2) allows for faster and more sophisticated diagnosis.

The test substances are clearly laid out in a radial pattern in plates. A radial row of five ampoules each can be checked and tested by rotating the plate. If a positive reaction is registered, the practitioner can test the individual ampoules within a particular row. The plates are easy to exchange and have a capacity of 150 ampoules. Placement of the ampoules is simple. Ampoules contained in the test sets can be used. The Selitest M uses a built-in measuring gauge and is based on modern microcausal techniques.

A further valuable and sophisticated aid for practical use is a **sender–receiver system**. The newly designed **ISE system** (infrared transmitter–receiver) by Regumed, Inc. has proven very effective for this purpose. The user has a choice between the integrated receiver in the BICOM device and the mobile version (Fig. 6.3). The sender is the same for both device types. The sender, with its brass plate that registers the information, is placed on top of the material to be tested. If several substances are underneath the brass plate, a positive reaction is registered if the patient is sensitive to at least

Fig. 6.3 ISE system (Regumed, Inc.). The information contained in the ampoules is registered by a brass plate attached to the bottom of the sender apparatus and transmitted wirelessly to the receiver. A cable connects the receiver to the patient and a measuring device (in this case an electro-acupuncture device). Besides the mobile version shown in the picture, a practitioner can also use the receiver integrated in the BICOM device.

Fig. 6.4 Sender apparatus of the ISE system, to be used in conjunction with an allergen test set. A slider (plastic with cork coating) is used to test individual ampoules or ampoule groups. Only the ampoules not covered by the slider are registered.

one, but not necessarily all, of the allergens. Individual testing or using the slider (included with the device, Fig. 6.4) quickly pinpoints the allergen in question.

The great advantage of the sender is that it allows for easy testing of native foods (i. e. in the original packing), textiles, cosmetics, toys as well as surfaces (e. g., of furniture). This gives patients the opportunity to bring "suspected" objects from their daily lives to the practice for testing. It has been effective to have people bring the vacuum cleaner bag. Placing the sender on the sample is sufficient; the test shows if we have to continue searching in the domicile (e. g., carpets, textiles).

Even though diagnostics is an absolutely crucial issue in physical allergy therapy—as treatment only makes sense with the correct allergen—the chapter dealing with it in this book is relatively concise and intentionally does not discuss any specific methods. Each of the diagnostic methodologies in question must be learned through experience and practice. Presenting them in a cookbook kind of way would only lead to unqualified tests. This would do more harm than good to the overall methodology.

7 Biophysical Allergy Therapy

Targeted Sites of Therapeutic Measures

Let us remember the thought modality of allergy mechanisms we initially established: A substance-specific **allergy imprint** created from within the informational level is activated by contact with the allergen. Subsequently, the biochemical immunological processes of an **allergic reaction** are initiated on the material level. Constant or frequent exposure to the allergen can transform the allergic reaction into a chronic allergic disease, which becomes increasingly independent, affecting the entire organism (see Fig. 3.3).

Figure 7.1 schematically illustrates the therapeutic possibilities and the targeted sites based on this thought modality:

At a glance we see that, to date, allopathic medicine is only able to use the small portion that relates to **allergic reactions**. The difficult holistic medical problems that arise from chronic allergies (i. e. the entire range of **allergic diseases**) are primarily the domain of naturopathic medicine.

The idea of treating the **allergy imprint** directly is still too new and unfamiliar for it to easily become lodged in people's—especially physicians'—

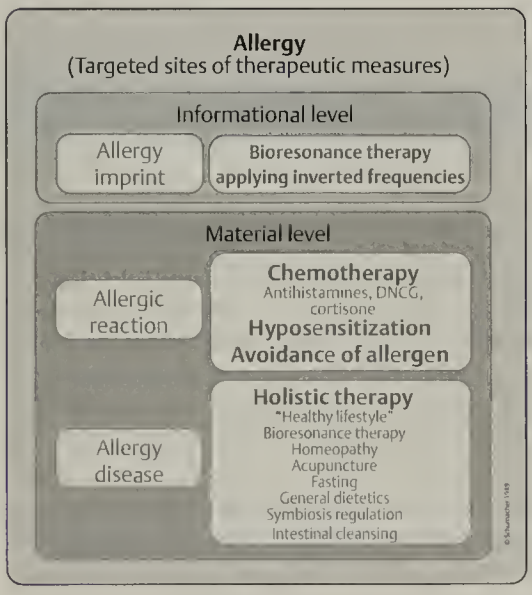

Fig. 7.1 General overview of available allergy treatments. (See text.)

minds. Nevertheless, when observing the diagram in Figure 7.1, it ought to be clear to any impartial observer that

> a therapy on the level of control and regulation has to be far superior to any other treatment methodology as it is effective even before any reaction takes place on the body's material level.

This applies to any therapy methodology on the informational level, particularly the entire field of bioresonance therapy.

The principle of the actual allergy therapy itself is incredibly simplistic. Anyone who has adopted the thought modality of biophysical medicine will find this easy to comprehend.

As we have tried to show and prove, the **allergy imprint** is the pivotal entity that determines any allergic reaction! It is characterized by a very specific, unique physics codification and is solely accessible via this codification. As previously seen, this codification can also be **manipulated**.

This, however, necessitates a physical trick, that is, the principle of **inverse oscillation**.

Inverse Oscillation as a Therapeutic Principle

An accepted law of physics states:

> Each wave, irrespective of amplitude and frequency, is reduced to zero, i.e. neutralized, when confronted with its opposite "mirror image" wave.

Figure 7.2 illustrates very clearly that when superimposing a wave progression with its exact mirror image, each upper (positive) amplitude of the original wave is neutralized by the same lower (negative) amplitude of the mirror image wave. When inverting (reversing into the mirror image) any frequency, the oscillation characteristic, i. e. the amplitude pattern of a frequency—as complex as it may be—does not change. However, this exact pattern (whether it is the original or the mirror image) is the specific codification that impacts the relevant imprint and influences the oscillation frequency.

Franz Morell was the first person to come up with this brilliant theory of using the mirror image of physical frequency information for therapeutic purposes. Based on this idea, he developed the methodology of treating pa-

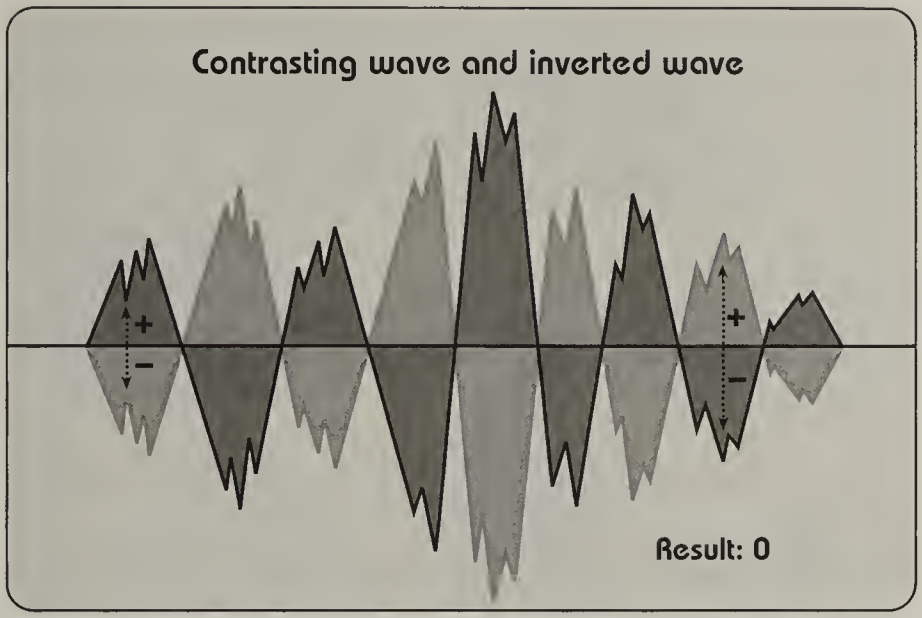

Fig. 7.2 Theory of mirror image. Superimposing a wave with its exact mirror image reduces wave information to zero (neutralized).

tients with their own frequency patterns. Eventually this gave birth to the current bioresonance therapy. The efficacy of bioresonance therapy today has been proven time and again.

Allergy Therapy Using the BICOM Device

Following in Morell's footsteps, G. Otten, a creative naturopathic practitioner, observed in 1978—in the early stages of the development of Morell's methodology—that allergic stressors may be reduced if the allergen is placed in the input beaker of the therapy device and inverted frequencies are applied.

In the following years, these findings were the foundation for a methodology whereby all substances to which the patient tested intolerable (or allergic) were placed in the input beaker of the device. The actual therapy consisted of inverting the oscillations at an 8-fold amplification, which was generally accepted as the correct application. This method improved the patients' tolerance to the relevant substances and diminished their symptoms. Complete healing, however, was illusive. Many years later (toward the end

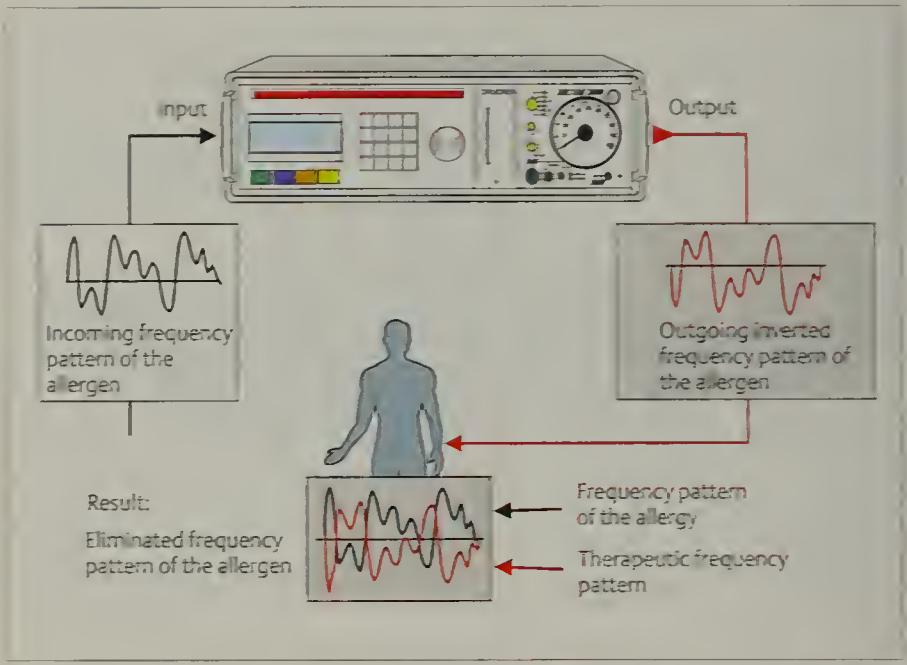

Fig. 7.3 Schematic representation of biophysical allergy therapy using the BICOM device. Frequency information is fed to the BICOM device via cables, where it is electronically inverted and transmitted to the patient as a mirror-image frequency pattern.

of the 1980s), based on our own experiences, we realized that certain other criteria would have to be met in order to completely cure an allergy.

Considering recent findings, we can explain (hypothetically) the effect of biophysical allergy therapy as follows:

The effectiveness of this therapy is based exclusively on inverted oscillations (mirror image frequency) of the allergen.

The therapy device electronically generates the mirror image of an allergen's original frequency. This inverted frequency is subsequently transmitted to the patient via cable and electrode (Fig. 7.3).

According to the aforementioned physical law, contrasting the inverted pattern coming from the device with the patient's frequency pattern results in a reduction in the original pattern through the mirror image.

The actual technical procedure is quite simple. It is merely a different version of the therapy modality using the patient's own oscillations as tradi-

tionally applied by the BICOM technology. The allergen is placed in the beaker electrode at the input of the device. We found that effective results can only be obtained if no more than one individual allergen is used.

For this type of allergy treatment, the patient is connected to the output of the device (as opposed to the therapy modality using the patient's own oscillations). He/she receives the allergen information inverted in the BICOM device via two hand or foot electrodes and/or a magnetic pad called a modulation mat.

All settings relevant for the allergy therapy are summarized in a program that is stored in the integrated computer of the BICOM device and can be activated by simply pressing a button.

The Possibility of Allergy Elimination

We made a fascinating discovery in the spring of 1988. Using the bioresonance method, it is possible to completely eliminate allergies, not just diminish their effect. We started with 100 patients who avoided all contact with one allergen during therapy. Almost all of them ceased reacting to that allergen after only six to eight therapy sessions. We originally used the parameters established by Morell as therapy settings for the device. These parameters were then incorporated into the development of the BICOM technology. The program, Code 999 in the BICOM computer, contains the following settings:

Program 999
A-Inv. = All information inverted
All frequencies
Continuous operation
Amplification 8
Time 4 minutes

This particular setting proved to be invaluable and has been used for many years by all bioresonance therapists. We also used this program exclusively for our studies regarding biophysical allergy therapy. As it turned out, it enabled us to effectively eliminate allergies. In order to achieve long-term success, however, several therapy sessions were necessary. Moreover, it was imperative that the patient avoid all contact with the allergen during the course of the therapy.

Figure 7.4 shows the correlation of the individual indices:

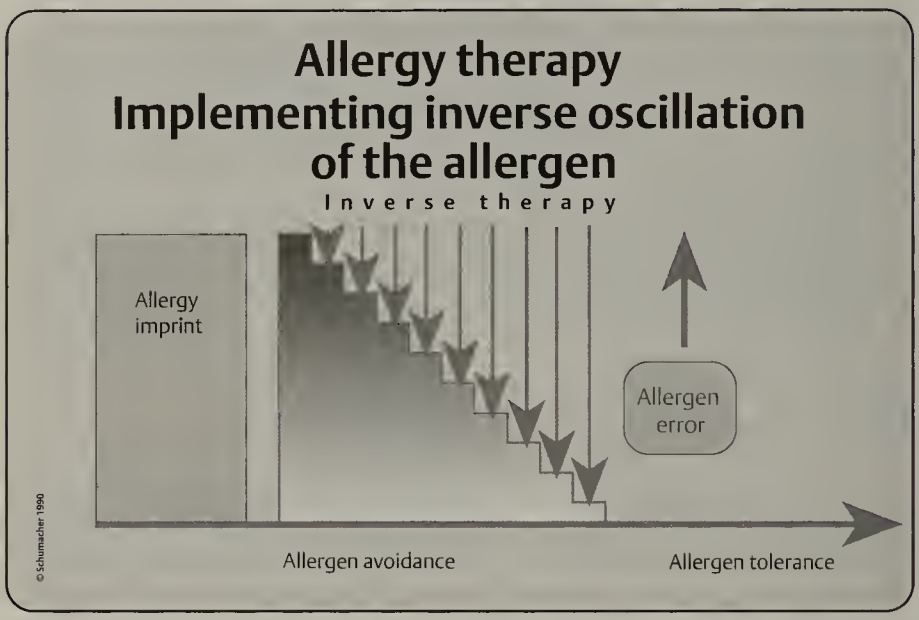

Fig. 7.4 How biophysical allergy therapy works: The inverse oscillation of the allergen methodically diminishes the activity of the allergen imprint in the patient's body until completely eliminated. An allergen error (that is to say contact with the original oscillation of the allergen) cancels the effect of the inverse therapy completely or partially. It prevents complete elimination of the allergy imprint and the allergy tolerance that had been established to that point.

Inverted oscillation therapy applied to the allergen (amplified 8-fold, as indicated by program 999) reduces the allergy imprint incrementally (arrows pointing downward) until it is completely eliminated. **At that point the allergen no longer causes any reactions.**

This process is interrupted or even terminated if the patient is consistently exposed to the allergen's original frequency or in contact with it at any time during the course of the therapy (upward error).

In our experience, diligent allergen avoidance is paramount to lasting therapy success.

A study of 200 patients who underwent allergy therapy as outlined above (we will discuss this study in detail later) **showed unsatisfactory results when contact with the allergen occurred during the course of the therapy.** In the case of a "constant error" (i. e. the patient was more or less exposed to the allergen the whole time during the entire length of treatment),

the therapy failed. Episodic contact with the allergen produced a certain therapeutic effect (the patient now tolerated the allergen, producing negative test results). In some cases there was a setback post treatment, that is, a recurrence of the allergy. The length of time varied according to the patient.

From 1988 to 1992, we and many other therapists have routinely used the therapy described here in conjunction with the BICOM allergy program 999. The success rate was excellent. When the therapy was performed correctly, 80 % to over 90 % of the patients were cured of their allergy.

Even though physicians and patients considered it a disadvantage, it was imperative to therapeutic success to **adhere to strict avoidance** of the allergen. Putting this into practice proved extremely difficult as absolute allergen avoidance meant "avoidance of the codification" according to biophysical findings. Not only does contact with the allergen need to be avoided, but also contact with its intangible frequency information.

It took us more than two years to conclude the importance of a genuine avoidance of the codification. Repeatedly, patients with severe neurodermatitis inexplicably relapsed. During these episodes the symptoms were profoundly acute even though the patients strictly avoided the allergen.

A farmer's child, whose case history is described below, finally helped us solve the puzzle:

Patient S. M., born in 1988

Neurodermatitis since infancy. Severe itching, partially wet eczema in the bends of the extremities, on the neck, and episodically on the entire body. Due to the unique clinical symptomatology and positive test results of an allergy to cow's milk protein, the diagnosis was cow's milk neurodermatitis. (See Neurodermatitis, Part II, for further details on the particular symptomatology of cow's milk neurodermatitis).

The family was informed and given detailed instructions. The child adhered to a strict diet without any cow's milk. After a few weeks, the skin condition improved significantly. Nevertheless the neurodermatitis inexplicably flared up again and again over the entire body (Fig. 7.5).

After some time we noticed that the condition often worsened on the weekends, even though the child continued to be on a diet exclusive of cow's milk products. After investigating the situation, we found that the child's adult brothers and sisters visited the mother on Sundays, as was customary, for coffee and cake. Strict attention was being paid to the child's diet, yet he was in the same room in which the mother warmed the milk and baked cake for his siblings. During the week, the mother only used goat's milk. On the weekends, however, she served the family cow's milk (although not to the child).

Fig. 7.5 Acute outbreak of cow's milk neurodermatitis caused by codification error. (See text.)

Fig. 7.6 Same patient as in Figure 7.5, allergy free.

We suspected that handling and warming the cow's milk released its information into the room and led to the hyposensitization of the child and the resultant eczema outbreaks.

The farmer's family began drinking only goat's milk, even on the weekends when the family visited. From this point onward, the child's condition remained stable, even throughout the weekend. The skin healed. After the cow's milk allergy was treated, the child completely recovered and remained healthy (Fig. 7.6). Since elimination therapy he has been able to drink cow's milk without displaying any allergic reactions.

Besides being an excellent example for the genuine avoidance of an allergen's codification of a hypersensitive organism, this situation is also theoretically interesting. Just like the findings of the research conducted by C. Smith, **it proves the existence and effectiveness of intangible information in a living system and its significance in subsequently creating allergic reactions**.

Many users of the bioresonance therapy, ourselves included, have been able to observe countless similar examples. This convinced us that it is indeed the specific information, the biophysical codification, which is crucial to strict avoidance of an allergen.

At this point the situation seemed clear: It was possible to genuinely "neutralize" an allergy under the precondition that strict avoidance of the allergen (i. e., avoidance of the allergen's codification) was essential during the therapy phase. Even though this was significant progress in allergy treatment, this was not the last word on the subject, as we will see later.

Biophysical Allergy Therapy without Allergen Avoidance

In the fall of 1991, the German physician J. Hennecke introduced a surprisingly simplistic, yet revolutionary methodology. Its technique was completely different from the ones previously described, but it also provided for the elimination of allergies. Based particularly on the methodology of the American kinesiologist, J. Scott, Hennecke succeeded in eliminating allergies by biophysically influencing certain acupuncture meridians. It turned out that this technique succeeded in eliminating the allergy with one single therapy. This occurred without the patient having to strictly avoid the allergen.

Conclusive data is not available to date. Meanwhile we have treated several hundred allergy patients with this method. Acute allergies respond particularly well to this method. It is also effective in the case of most contact allergies.

Relapses seem to occur somewhat more frequently. This being a time-saving and significantly simpler method compensates for that circumstance. With regard to chronic allergies, in particular severe forms of neurodermatitis, caution is advised. In our experience to date, patients with difficult to treat clinical symptomatologies should continue strict avoidance of the allergen for a sufficiently long period of time.

To attempt a shortcut with this simplified procedure often leads to acute worsening of the symptoms.

We will mention this aspect again in Part II when discussing neurodermatitis in more detail.

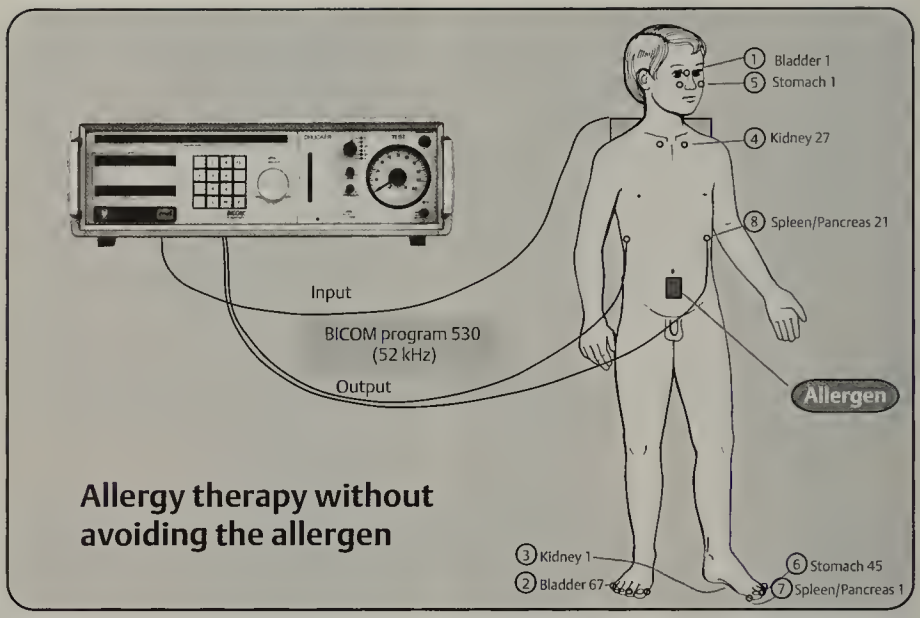

Fig. 7.7 Allergy therapy relating to meridians according to Hennecke. The allergen is placed underneath the navel. The beginning and end points of bladder, kidney, stomach, and spleen/pancreas meridians are treated in this order at a frequency of 52 kHz (BICOM program 530).

Hennecke's technique is particularly easy for someone familiar with acupuncture. A glass ampoule containing the allergen is placed below the navel. It may be attached with a band aid, elastic, or a belt. The original, not the potentized, substance is suitable here. The bioresonance test set ampoules may be used as well. Subsequently, the beginning and end points of the bladder, kidney, stomach, and spleen/pancreas meridians are treated, in this order, using a bandpass median frequency of 52 kHz for 1 minute each.

Program 530 of the BICOM device is used for this purpose. The input electrode is a large flexible electrode attached to the shoulder/neck area.

The acupuncture points (beginning and end points) are touched simultaneously with two knob or "gold-finger" electrodes for approximately 60 seconds each (Figs. 7.7–7.9). The patient may be supine or sitting during this treatment.

When using this method, the allergen used should be as unadulterated as possible. Mixed antigens are significantly less effective or maybe non-effective.

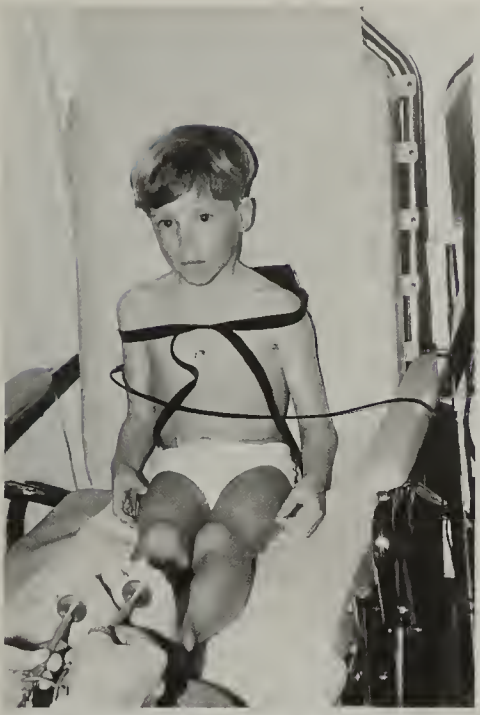

Fig. 7.8 Illustrates allergy therapy technique relating to meridians according to Hennecke. The relevant acupuncture points (shown here is Kidney Point 1) are treated for 60 seconds each with two electrodes connected to the output of the BICOM device (BICOM program 530 = frequency 52 kHz). We often have mothers conduct the treatment on their children after appropriate instruction.

Fig. 7.9 Treating Kidney Point 27 simultaneously with two electrodes.

Hennecke's idea of treating allergies via acupuncture meridians was employed by numerous therapists. At times modification was attempted. In our experience the points selected by Hennecke are sufficient. The method turned out to be effective, is easily delegated to staff, and the time spent on a patient is reasonable for a medical practice.

It should be said that therapies are in a constant state of flux. Further versions of therapies will continue to develop.

The new idea here is that the body can pick up allergen information simply through direct contact. The area below the navel, in the general vicinity

The points in detail		
1	Bladder 1	Medial angle of eye
2	Bladder 67	Outer nail fold of the small toe
3	Kidney 1	Middle of the ball of the foot
4	Kidney 27	Sternoclavicular joint
5	Stomach 1	Jaw bones below the center of the eye
6	Stomach 45	Outer nail fold of the second toe
7	Spleen/Pancreas 1	Inner nail fold of the big toe
8	Spleen/Pancreas 21	Axillary line, middle between armpit and height of the bend of the elbow

of the conception vessel (acupuncture point cv6), seems to be particularly suitable. Positioning the allergen ampoule two fingerbreadths below the navel for the duration of the therapy seems sufficient to transmit adequate amounts of the allergy information to the patient's frequency system.

Again the BICOM technology is used for the treatment: A large flexible electrode in the shoulder/neck area registers the entire frequency spectrum (including the body's reaction to the allergen information). It is then fed to the input of the BICOM device via cable. The BICOM technology modulates this information into therapeutic frequencies. These are transmitted simultaneously to the beginning and end points of the relevant acupuncture meridians. Flooding the meridians with the therapy signals emitted by the BICOM device seems to effect the necessary changes in the organism.

Many bioresonance therapists immediately employed Hennecke's therapy variation. While it has significant advantages, such as rapid success after one to two therapy sessions and, above all, reliable effectiveness without avoidance of the allergen, it does have a small disadvantage, which would only make an impact in an extremely busy practice. It takes longer (about 10–15 minutes per therapy) and requires an additional member of staff to attach the electrodes. (In order to keep our staff relatively free, we always ask for a companion to come along when using this treatment methodology).

Another completely new method was discovered in the spring of 1993. It is a continuation of the original method with the input beaker of the BICOM device containing the allergen and the application of program 999.

In close cooperation with Paul Schweitzer, the German physician Theodor Klein discovered that lasting therapeutic effects were obtained under

certain physical conditions coupled with simultaneously applying highly amplified information of the allergen's mirror image.

Numerous experiments have proven that the long-time methodology of program 999 can be improved upon significantly if certain geometric laws are taken into account. The way in which an allergen's information is passed to the therapy device seems to make a difference. The results are better if **two cables** are connected to the input beaker, provided that their drill holes are aligned at **right angles** to each other.

The placement of the output electrodes in the room also seemed to play an important role. When plate electrodes were used, the best results were

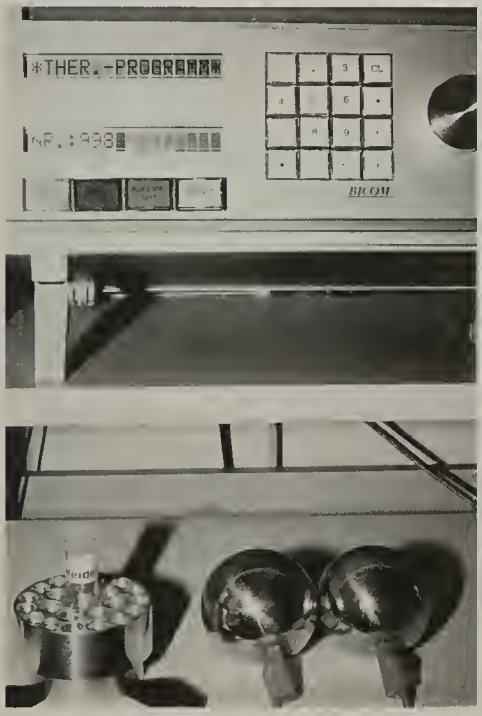

Fig. 7.**10** Special electrodes for therapy with amplified inverted frequencies (according to Klein and Schweitzer). The input electrode (beaker electrode) or electroacupuncture honeycomb must have two drill holes that are at right angles to each other. They connect to two input cables. Two brass balls are used as output electrodes.

Fig. 7.**11** Allergy therapy (according to Klein and Schweitzer). The allergen is connected to the device via two input cables. The patient holds ball electrodes in both hands.

obtained when they were held perfectly horizontally. Further tests showed that this requirement was difficult to meet in practice. It does not have to be adhered to if ball electrodes are used instead. Regumed, Inc. offers suitable ball electrodes as well as input beakers with drill holes at right angles to each other as accessories to the BICOM device (Figs. 7.**10** and 7.**11**).

Doubtlessly, the most important aspect for the most effective allergy therapy was the magnitude of **amplification of the allergen information** in the BICOM device.

Based on the value proposed by Morell, program 999 contains the 8-fold amplification. If this value is amplified 64 times, the maximum possible with the BICOM device, the effect of the inverted frequency seems to be significantly more intense.

In 1994 a new program, number 998, was introduced with the following settings:

Program 998
A-Inv. = All information inverted
All frequencies
Amplification 64
Interval setting
Time 3 minutes

Surprisingly, over the past few years no one, including ourselves, had thought about experimenting with the amplification of the allergen. People were satisfied with the new, tantalizing possibility to neutralize allergies. They accepted the disadvantages of frequent therapy sessions and the necessity of avoidance of the allergen. Even though it was based on a completely different theory, Hennecke's method proved that the field of physical allergy therapy had not been exhausted.

This caused many colleagues to begin experimenting and consequently to go their own way (Altrock, Cornelissen, Dufkova, Krimplstätter, Tjiang). It turned out that other techniques were equally effective, for example in combination with the points of auricular acupuncture. Although these other versions are effective, at times they tend to be a little more complicated and time-consuming.

Even though this was a new methodology at the time, allergy program 999 proved to be practical because it was easy to implement and reliably effective. Many therapists soon adopted it as their standard method of treatment. We have used it to successfully treat several thousand allergy patients since the first experiences in the spring of 1993.

To date there is no data available from case studies. However, the efficacy of the methods for the elimination of allergies is so clear that a statistical representation of its successes would only be necessary to make the method plausible to non-practitioners. Anyone familiar with this methodology already considers the elimination of allergies as a given. It is simply a question of what kind of therapy to select. Statistical proof of its effectiveness is no longer required.

Most patients do not need to avoid the allergen during treatment. Yet, as in any other version of biophysical allergy therapy, the following rule applies: In the case of severe, chronic allergies, the organism must be prepared for the actual allergy therapy by avoiding the allergen for a sufficiently long period.

In the case of hyposensitized patients, we recommend the individual testing of the settings on the BICOM device. In all other cases—even infants and babies—the settings of program 998 can be used without modification.

We owe further pivotal developments to Hennecke. He also discovered that a treatment with frequency 52 kHz, effective for meridian therapy, is more easily applied if ball electrodes are used. It is particularly suitable for treating "natural" antigens, specifically allergies to foods. **BICOM version 4.1** contains a program (997) explicitly addressing this issue. Here, too, the allergen is placed in the input beaker while the patient holds two ball electrodes connected to the output of the device.

The theory of amplification added to the findings. It turned out that in some cases incrementally increasing the amplification was superior to keeping it at one constant level during the course of the therapy. This incrementation proved effective for program 998 as well as 997 and was integrated into BICOM version 4.1 as an optional program.

Available since the end of 1997, the new version 4.4 of the BICOM device included various other fundamental improvements.

Again, among those is the amplification. Calculated observations showed that very specific amplification levels would extract particularly strong reactions from the patient. In the same amount of time, proficient testers have had greater success testing each individual amplification setting.

The **automatic amplification sweep** of BICOM version 4.4 inevitably takes into consideration the best, individual amplification: During a therapy session of 10 minutes all amplification levels, from 0.025 to 64-fold, are passed through 50 times, and subsequently "hit on" the individual, most effective amplifications. Several years of observations demonstrated that this amplification sweep is superior to the constant amplification setting as well as the incremental increase. This electronic setting proved effective for the basic programs (formerly programs 100 to 105, now programs 130 to 135). In particular this applies to the **three new programs for allergy therapy.**

There are three allergy programs due to the fact that according to more recent findings, using a **substance-specific frequency range/bandwidth** increases the therapy's effectiveness (Cornelissen 1993). Each of the new programs is programmed to a specific frequency range/bandwidth.

Program 977:
Essential substances (mainly foods) react best to the frequency range/bandwidth of around 52 kHz (see also programs 530 and 997). The bandpass oscillates around the median frequency of 52 kHz. Therapy type "**H+Di**" is the most effective therapy for foods. After extensive tests, Cornelissen and Würthle realized that it is more beneficial to associate a high amplification of "Di" with the largest attenuation of "H". For this reason a **reciprocal amplification** sweep was developed, a significant component of program 977.

Program 978:
This program works with **frequency range/bandwidth 24 kHz** and is best used for stressors such as **viruses, bacteria, fungi and pollen.** The therapy type is "**A-inverted.**" Here, too, the bandpass oscillates through a wider range of frequencies around the median frequency of 24 kHz. The amplification sweep of 0.025 to 64-fold is repeated every 12 seconds during a 10-minute therapy session.

Program 979:
The stored **frequency range/bandwidth of 11 kHz**, i. e. the bandpass, oscillates through a wider range of frequencies around 11 kHz. The therapy type is also "**A-inverted.**" This program is used for any intolerances to **chemicals, metals, and environmental toxins** and any stress placed on the organism by these stimuli. Here, too, the amplification sweep of 0.025 to 64-fold is in 12-second intervals.

The differentiation of the programs leads to an increase in accuracy, significantly improves the therapy's effectiveness, and often negates the need for individual testing of the therapy parameters.

Therapy results improved tremendously with the introduction of the BICOM 2000; it returns to the patient the frequency pattern of the substance as well as the patient's own frequency pattern via a magnetic mat. Modification of the previously described therapy programs is no longer necessary.

Biophysical Allergy Therapy in Practice

In Part II we will elaborate on the various allergy–related clinical symptomatologies from the biophysical point of view. The following is a general overview of therapeutic methods with regard to individual allergy types:

Acute Allergies

The simple acute allergies are easily recognized and treated. Symptoms usually occur in obvious conjunction with or after contact with the allergen.

Using the latest therapy methodologies without avoidance of the allergen, **the patient can be immediately treated after diagnosis**. This also applies to seasonal allergies (e. g., hay fever). Other allergies where exposure to the allergen is unavoidable (e. g., to house dust mites or mold in the house) are also included.

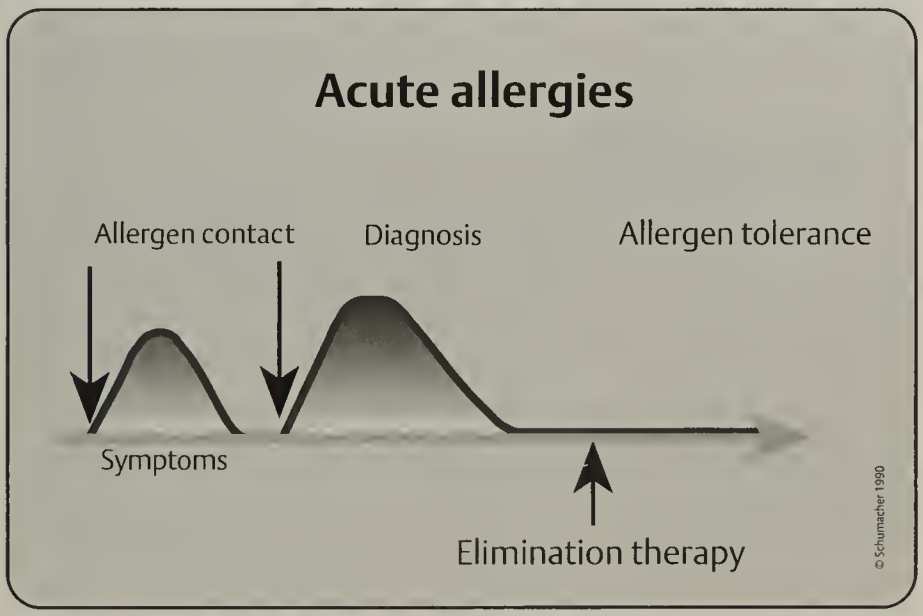

Fig. 7.12 Schematic treatment of acute allergies: Symptoms appear after contact with the allergen. They subside after several days if there is no further exposure to the allergen. After the allergen has been identified, allergy therapy can take place immediately. If the diagnosis was accurate, the patient will no longer react to the allergen in the future.

Several acute allergies in the same patient can be treated sequentially. If possible on a given day, we treat only biological or chemical allergens. We prefer to have the patient come in again for further treatments. In our practice, we conduct approximately two to three treatments per allergen on separate days. In special cases, if the patient lives far away, the number of treatments can be reduced to one. It has generally been beneficial to check on the patient's progress for a period of several days, up to weeks, after the initial therapy. In this way we can control the therapy effect (and consequently, the accuracy of our diagnosis). Another treatment with the allergen conducted at this point gives the patient an increased sense of security.

The following standard treatment has proven effective: treatment is begun with the "unspecific" program 998 (including amplification sweep),

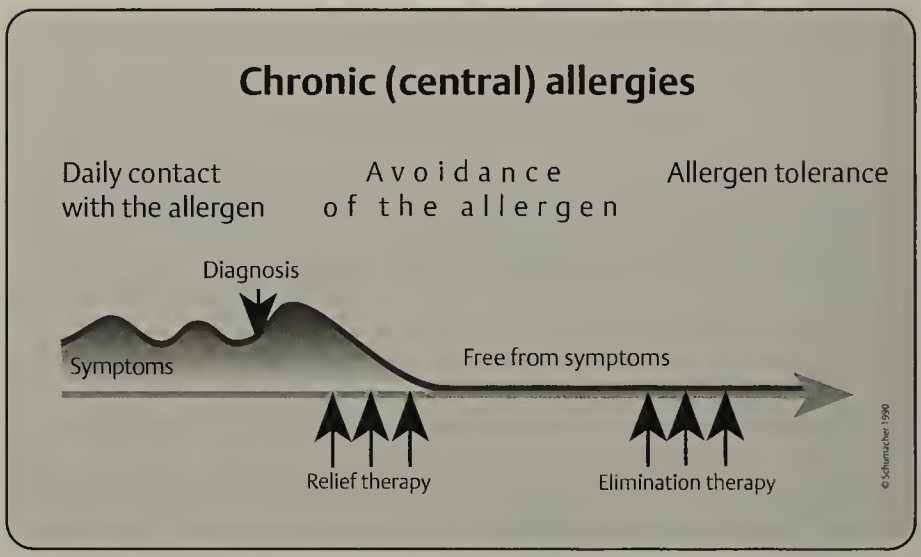

Fig. 7.13 Schematic treatment of chronic allergies: The symptomatology differs for chronic allergies (daily or constant allergen exposure). Their severity depends on the overall condition of the patient and the influence exerted by the various additional stressors. The masking effect makes it difficult to establish a direct correlation of the symptoms to the allergen. Removing the allergen de-masks the allergy, which leads to increased sensitivity (particularly dramatic is a renewed, unexpected contact with the allergen in the period in which it is meant to be avoided). There is no specific time limit for the subsequent avoidance of the allergen. Initially the patient has to learn how to properly avoid exposure to the allergen's codification. Allergy symptoms should improve significantly. Relief therapies are frequently indicated for this phase.
The actual elimination therapy should not be initiated until the symptoms have subsided substantially or disappeared. Following the elimination therapy, the patient tolerates the allergen and is no longer required to avoid it.

then, depending on the allergen, we conduct a treatment with the substance-specific frequencies (program 977, 978, or 979).

Figure 7.12 illustrates how we treat acute allergies in comparison to chronic allergies (Fig. 7.13).

Chronic Allergies with Low-Level Sensitization

In the case of chronic allergies (allergies to a food staple consumed daily or frequently), treatment depends primarily on the **level of sensitization.**

Patients with moderate or low-level sensitization and mild symptomatology can usually be treated immediately. A recent mild cow's milk allergy, with concurrent mild neurodermatitis, can be categorized as an acute allergy. It is treated the same way as described above.

Chronic Allergies with High-Level Sensitization

Naturally, this group includes the most difficult to treat cases. The symptomatology is severe (**neurodermatitis, asthma, colitis**, etc.) and often stresses the patient to his/her limit. Moreover, often many ineffective treatments have discouraged the patient. This has to be taken into consideration in the initial consultation.

Many people with neurodermatitis are **hyperergic** and react to incredibly minute amounts of the allergen. At least this is the case at the beginning of the avoidance period. The patient **must** have a clear understanding of the term **intangible allergen information** (physics codification of the substance) in order to avoid such situations accordingly.

Within the context of the allergen resonance test, hyperergy can be easily and simply tested for by means of a slide test. The test has proven very effective in assessing the patient's level of sensitization and serves as a demonstration to the patient. The patient is always very impressed when he/she sees that even the invisible information of the allergen, vapor deposited onto a clean slide, represents a highly potent allergen. The first and foremost advice we give these patients is **to immediately and completely eliminate this primary allergen from his/her daily life.** Besides completely eliminating all products containing cow's milk or wheat from the house, all family members living in the same dwelling are inevitably subjected to the same strict rules as the patient. If visiting others, the patient should make certain that on that day nobody has handled, cooked, or baked anything containing the relevant allergen (cow's milk or wheat). Restaurants, cafes, pastry shops, bakeries, grocery stores, etc. have to be avoided! (The hyperergy will be discussed in more detail in the section on neurodermatitis in Part II.)

These rules signify an extreme interruption of the daily life of both the patient and his/her family. The necessity is soon proven when the symptoms dramatically worsen after the first mistake has been made. At least, at this point, the patient is motivated enough to voluntarily accept the restrictions and limitations.

Particularly important to the patient is the realization that he/she has been introduced to a therapy methodology that is meaningful and whose goal he/she strives to achieve.

The goal is the elimination therapy, which, in the case of hyperergic patients, can normally only be carried out after several weeks. It is, so to speak, the completion of the therapy and the reward. A series of **three to six relief treatments** with the BICOM device in the intervening period have proven effective. These treatments aim to provide general relief for the patient and to gradually decrease the level of sensitization. At least in the beginning, it is important to take into account the patient's extreme hypersensitivity, as he/she may react strongly to the minutest stimulation. For a **basic therapy**, designed for general relief, we choose a program with an "A-inverse" setting (i. e. inversion of the entire frequency spectrum and an amplification of far below 1.0). We have found **program 101** to be effective in our practice. Initially, we reduce amplification and duration considerably (0.25–0.5 of the originally programmed values) and subsequently increase them depending on the patient's tolerance of the treatment. Whenever possible, the settings should be tested individually.

The **specific treatment designed to alleviate the allergy using program 999** follows the basic therapy. For program 999, the allergen is placed into the input beaker; the patient is connected via two electrodes. The cables are connected to the output. Here, too, amplification and duration settings are significantly reduced (if possible, the settings should be tested) and slowly increased depending upon how well the patient tolerates the treatment.

The settings we use for the elimination therapy should be avoided at this stage of high sensitization. At this phase in the treatment, we also urgently advise against the use of "allergy drops" (drops *charged* with the mirror image information of the allergen). Even a carefully prescribed dosage may cause severely detrimental reactions. The actual **elimination therapy** (two to three treatments with program 977 or 998 are common, possibly one after the other on different days) should not be initiated too early. It is best to wait until most of the symptoms have significantly subsided to obtain the best results (Fig. 7.13).

Many patients with neurodermatitis have **multiple allergies**, that is, besides their central allergy they also have allergies of varied **acute allergens**, be they in the food sector, inhalation or contact allergens. The time period before the elimination of the central allergen can effectively be used to eliminate these superficial allergies one after the other, step by step. The patient can determine the order depending on how important and bothersome he/she considers the individual allergy symptoms to be.

As already mentioned, we do not like to treat multiple acute allergies in one treatment session. In the case of highly sensitized patients with neurodermatitis, severe asthma, etc. who are susceptible to overreactions, we also handle these accompanying allergies with particular care.

Factors That May Influence Treatment Results

Technically speaking, biophysical allergy therapy is quite simplistic. Acute allergies rarely present any real difficulties; unlike chronic types, especially if they have been present for a long time and have caused a genuine allergic disease.

Many criteria have to be considered for neurodermatitis or chronic-allergic bronchial asthma to be truly eliminated. Physician and patient have to work in perfect harmony to attain this ambitious goal.

Diagnostic Errors

Allergy therapy on the informational level is possible only when the **specific allergen is known** and its **information is available.** Thus the diagnosis is crucial for the success of the therapy.

Disregarding the, to date, still difficult chronic allergies that require a physician's entire repertoire of knowledge and skills, biophysical therapy with the BICOM technology has obtained such a high standard that failures usually are caused by misdiagnoses. Therapy depends almost exclusively upon the diagnosis. This is one of the main difficulties for allopathic medicine to agree with, which we will illustrate later.

Based on misdiagnosis, there is no way biophysical therapy can deliver successful results, no matter how strongly one believes in one's own diagnosis!

Diagnostic errors may occur for a variety of reasons:

Misdiagnosis of Immunological Test Results

Besides possessing various disadvantages (bothersome and stressful for the patient), all allopathic allergological tests (skin tests, blood tests, etc.) register only what occurs on the **material level**. For our purpose the results are often unusable. Positive proof of specific antibodies does not reveal much about the actual relevance of the allergic incident.

Testers' Errors

All tests relating to the informational level are sophisticated, do not stress the patient, and allow efficient testing. All of them make great demands on the tester. Any test methodology used must be studied thoroughly and practiced sufficiently. Insecurity, timidity, lack of concentration or the fatigue of the tester may cause errors.

Mistaken Use of the Terms Allergy and Intolerance

Misdiagnosis applies above all to informational level techniques. If conducted by an unqualified tester, even techniques functioning at that level may not be effective. These include for example electro-acupuncture, auriculomedicine, and kinesiology.

One of the significant disadvantages of these methods is that positive test results can be achieved when the relevant substance **stresses** the patient, for whatever reason, at the time of testing. This leads to **too many positive results**. Differentiating between genuine allergies and stress reactions in the toxicological sense requires experience. The following example demonstrates how problematic a misdiagnosis can be for a patient:

Patient L.A., born in 1987
Neurodermatitis was evident from infancy. During the third year, a colleague used electro-acupuncture to conduct several elimination therapies. None were effective.

At the age of four, additional occurrence of bronchial asthma that worsened dramatically. Another bioresonance physician, eventually consulted, found 70 allergens (!). Understandably, this placed the family in a state of complete uncertainty, particularly as there was **no differentiation of significant, central allergens and insignificant, acute allergens**.

The patient eventually ended up in our practice and showed the clinical symptomatology of classic cow's milk neurodermatitis concurrent with eczema, particularly on the face and extremities. Additionally, there was pronounced bronchial asthma. Test results for cow's milk and chicken egg protein were positive, also for horse epithelia and sheep's wool. Positive candida was in the stool.

After rectal ozone therapy to eliminate the intestinal candida, strict avoidance of cow's milk, and finally allergy therapy, the skin condition dramatically improved within a few weeks. Asthmatic reactions no longer occurred.

It is obvious that initially this patient was misdiagnosed. Therefore physical therapy was ineffective. The second diagnosis contained the correct allergens. However, these were concealed in a completely confusing array of erroneously positive test results. Neither the patient nor the therapist knew what to do with these.

Misdiagnosis is responsible for complete therapy failures. If a patient is treated with an allergen that is not relevant to him/her, obviously the allergy will not change. Other factors may call into question the result of a fundamentally accurate allergy therapy. In most cases the allergy appears to have been eliminated. However, the patient may experience a relapse after several weeks or months.

Geopathic Stress

Geopathy, an emotive word for some people, is for many others a self-evident, environmental condition that may very well influence our life and health. More than 4000 years ago imperial laws existed in China which stated that edifices and dwellings where people congregated and/or lived were not to be built in a location unless a priest or physician had previously checked the site for the presence or absence of "evil earth spirits." We do not want to elaborate on this subject in this text. We do not intend to enter into the unabatedly active discussion between pure natural sciences, radiesthesy (categorized among parascientific disciplines), and medicine based on energetic physical principles.

Anyone who commonly works and treats using the finest physical energies and information cannot however ignore the geopathy factor.

Geopathic stressors are location-related influences that—as experience has shown—may very well cause illness in an organism. These location-related influences may be:

- So-called **earth rays**, for example, caused by water veins but also by ore, coal, mineral deposits, or geological faults.
- The global grid runs north to south as well as east to west across the globe forming a checkerboard pattern (Hartmann Grid). As the locations of the lines vary, only in rare instances is it considered a chronic stressor. The second grid system, named after the German physician M. Curry and known as the **Curry Grid**, runs diagonally to the Hartmann Grid. Its lines are stable and can definitely cause disturbances. The points where the lines intersect are particularly powerful. The fields of disturbance caused by the above-mentioned earth rays coupled with the Curry Grid are equally powerful.
- Increasingly common is a third factor, **electromagnetic environmental pollution** (Becker 1990). Today, radio and TV signals, microwaves, radar, high-voltage lines, etc. span the entire globe. Additionally, we have electromagnetic stressors in our homes, such as electrical devices, clocks, neon filled tubes, TVs and radios, cellular phones, electrical wiring.

The common denominator for all these disturbing influences is that they can profoundly affect energetic processes, frequency and informational processes of animate systems on the electrical, magnetic, electromagnetic, electrostatic, or radioactive level. In a human being with stable health who is not otherwise stressed, the effects are usually unnoticeable and are neutralized by natural balancing mechanisms. Only if somebody has been exposed continually to stress for many years, even decades (e. g., sleeping in a bed located in a field of disturbance), or in extreme situations (e. g., several disturbing lines intersecting or under extreme electromagnetic stress), can they cause illness. The symptomatology is usually uncharacteristic:

- Children primarily experience: sleep disturbances, nightmares, bedwetting, as well as problems in school. In her book *Erfahrungen einer Rutengängerin* (Experiences of a Dowser) published in 1977, Käthe Bachler, a teacher and, at the same time, practitioner of radiesthesia cites her pioneering work in this field.
- Adults experience: sleep disturbances, also typically grogginess in the morning, irritability, headaches that take on varied forms, as well as a lack of concentration; in addition, any kind of rheumatic complaints and, finally, the much-discussed carcinogenic effect contributing to the onset of cancer.

Geopathic disturbances exert more influence, more quickly on patients who are exposed to additional stressors besides geopathic ones. People with allergies are never completely free from stress as their allergy is already a stress factor. In many cases a mosaic of disturbing factors are in col-

laboration. Experience has shown that biophysical therapy of allergies may be impeded or completely blocked if the therapist does not recognize or ignores (i. e. does not eliminate) relevant geopathic stress.

Any method may be used to test for geopathic stress. In our opinion this test should be part of a standard diagnosis for every allergy patient. It is generally intended to prove geopathic stress in a patient without initially going into specifics.

If the test result is positive, we always consult an experienced practitioner of radiesthesia. If possible, he/she should have the necessary measuring devices available to test for electro-stress. Once the necessary corrections have been made, an additional geopathic test is administered to verify the elimination of the disturbance. Only then do we begin the allergy therapy.

We know of many cases where geopathic stress, which had not been recognized up to that point, was ascertained using allergy diagnostics. The patients experienced unexpected relief from such a diagnosis.

We would like to illustrate this with a particularly intriguing example. It involves fraternal quadruplets, two girls and two boys, all born on the same day in 1985.

They first came to our practice at the age of three (Fig. 7.14).

Fig. 7.14 Fraternal quadruplets, all geopathically stressed; three of them have allergies. The girl second from the left is the most affected. She is considerably smaller than her siblings of the same age.

The boy on the far right of the photo was the only one who was healthy and free from allergy symptoms, though he was below average in height and weight for his age group. One of the girls was the most affected (second from the left). Since infancy she had had severe neurodermatitis. Additionally, more recently, she had experienced increasing asthmatic symptoms. The severe allergic stress had also influenced her physical development. She had always been the smallest and weakest of the four siblings.

The other two siblings also had allergy symptoms in the form of urticaria, chronic allergic cough, and pollinosis. All the children had a hard time sleeping at night, were restless, cried often, and were prone to nightly head sweats.

Biophysical diagnostics resulted in a positive test for geopathic stress for all four of the children, in addition to their multiple allergies. Geopathic fields of disturbance almost always occur in the form of negative ley lines. Thus, it is rather uncommon for several inhabitants of a dwelling to show stress symptoms at the same time unless all of them sleep on the same ley lines. That was exactly the case. All the children had lined up their beds along one wall and were situated above a wide water vein circulating coun-

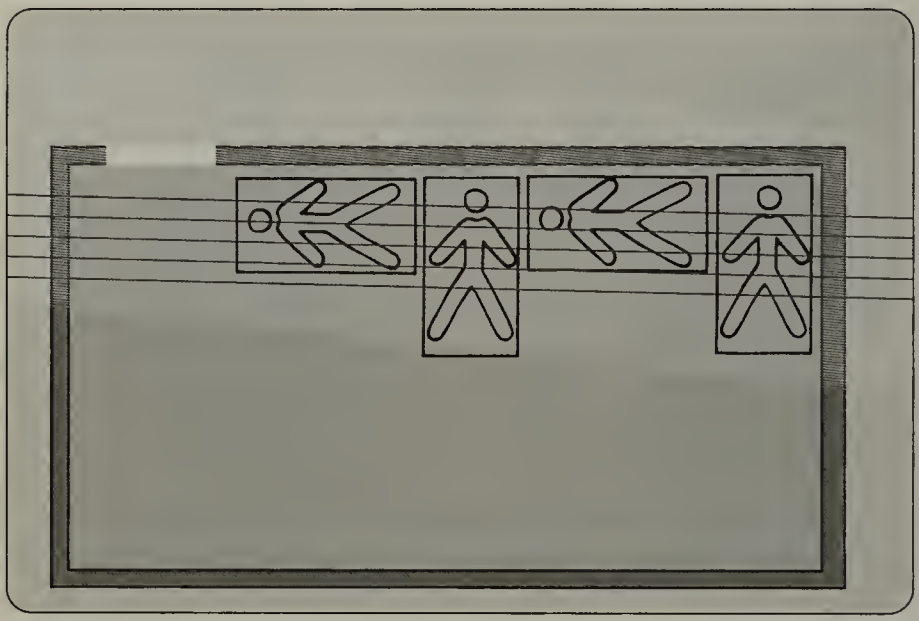

Fig. 7.**15** Radiesthetic findings of the same children as in Figure 7.**14**. All four children sleep in beds lined up on an intense water vein that circulates counter-clockwise. Lines of the Curry Grid, running parallel to the water vein, exert an additional influence.

ter-clockwise. This was intensified by lines of the Curry Grid, running almost parallel to the water vein (Fig. 7.15).

The children's beds were immediately moved into an area free from disturbances. The children were systematically treated for the different allergies: The boy to the left of the photo was treated for a goose down allergy and subsequently hazel pollinosis. The taller girl suffered from relapsing urticaria, which was traced back to an allergy to azo dyes. We treated first with tartrazine (E102) and then with the red colorant E124.

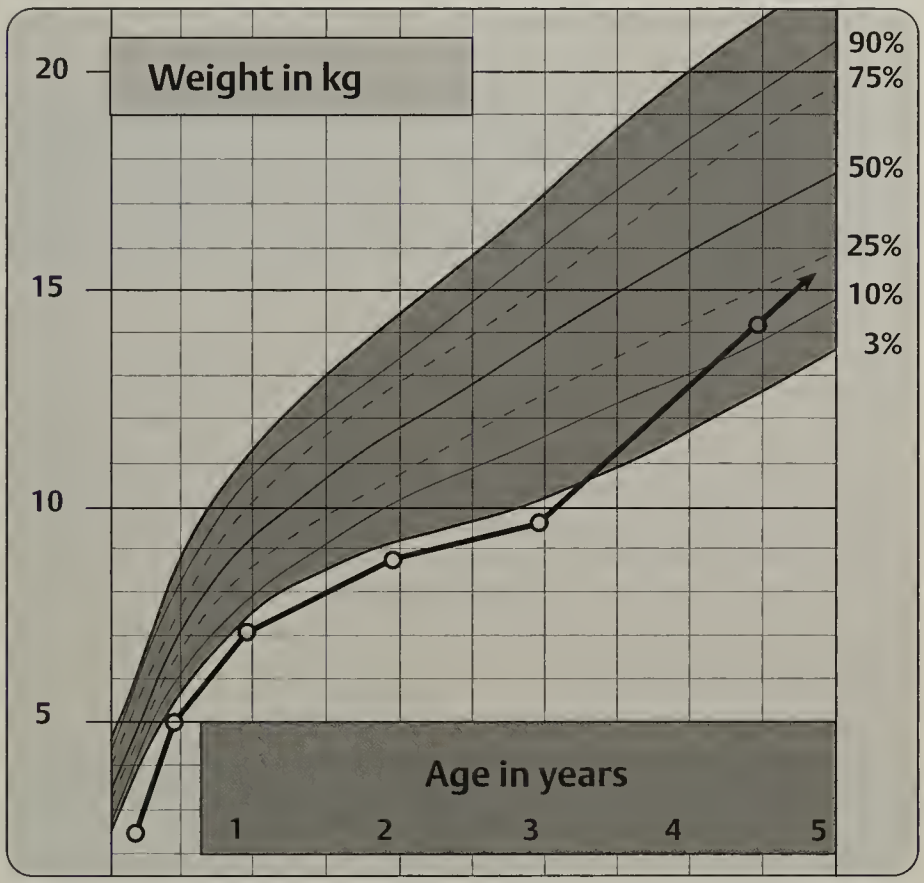

Fig. 7.16 Weight curve of the same girl as in Figures 7.14 and 7.15, who suffers from severe neurodermatitis and asthma. During the first 3 years of her life the weight curve was always below the 3rd percentile, which is the lowest standard.
After discovering and correcting the geopathic stress and simultaneously starting allergy therapy (at the beginning of the 4th year), the weight curve shows a clear upward trend with a jump in percentile of more than 10% within 1 year. Further progression shows a continual increase of the curve and by the 6th year it is already close to 25%.

The girl who suffered most, from neurodermatitis and asthma, was the most difficult to treat. Her therapy took the longest. After eliminating the geopathic stress, we initially cleansed the intestines (she had massive candida). She had tested positive for cow's milk and wheat. Following the intestinal cleansing, she underwent elimination therapy and had to avoid exposure to the two central allergens to the point of isolation—first cow's milk, later wheat. In the course of the next two years we treated several acute allergies (cats' epithelia, walnuts, grasses, horse epithelia). The original allergies to citrus fruit, peaches, and kiwi which tested positive disappeared by themselves after treating the central allergens.

We have been treating the children for more than 3 years. They are all healthy now and have been allergy free for the last 2 years. The girl who originally had neurodermatitis and asthma regained her health. Her skin is still a bit rough at times and susceptible to mycosis. Her bronchial system sometimes responds to infections with a tendency to spasms.

The progression of this girl's development is interesting. This is demonstrated in the weight curve during her first 5 years (Fig. 7.16). During the first 3 years of her life, the weight curve lies significantly below the low standard range of the 3% percentile curve. Starting with the fourth year (elimination of geopathic stress and beginning of allergy therapy), the curve shows a significant upward trend with a percentile increase of more than 10%.

Besides showing the impact of geopathic stress (without geopathic diagnosis, progress would certainly have been less positive), the case history of these four siblings is a good example to illustrate the beneficial possibilities of biophysical therapy. This therapy modality helps entire families to be restored to good health. Without biophysical therapy, the fate of many atopics would most likely turn out quite differently.

Acquired Stress Factors

The more simplistic the technique for treating allergies becomes, the higher the danger of **considering the allergy to be treated as an isolated disturbance** whose elimination is easy. It then seems unnecessary to pay closer attention to the individual as a whole.

Easily overlooked is the fact that the carrier of this disturbance is a human being of our times, stressed by many harmful things in our world, from which we are unable to escape. It is a human being who might not have developed a particular allergy had his/her entire being been oscillating freely and unburdened, as engineered by Nature.

Of course, the extent of **acquired stress factors** depends significantly upon age. They play a relatively small role in children, which is why they have the highest rate of success and are the least problematic.

In the case of adults, it is imperative to recognize and treat the many possible influences that may have arisen from an **imprudent way of life** practiced for many years, even decades, or from **previous treatments or "mistreatments" of the patient**.

Anyone who conducts biophysical allergy therapy by itself whilst disregarding the multitude of the patient's additional stressors is unlikely to attain any of the otherwise possible therapy successes!

The following stress factors (besides the geopathy discussed previously) should be addressed and treated before the onset of the actual allergy therapy:

- **Intestinal dysbiosis**, specifically overgrowth of candida in the intestine
- **Scar tissue interferences**, particularly in the head and neck area
- **Lack of minerals and nutrients**
- **Toxic stress** (amalgam, domestic toxins, etc.)
- **Viral stress**

All of these stressors require a **holistic therapy approach. Classical bioresonance therapy**, with its harmonizing, stress relieving, and detoxifying effect, may be combined with any other detoxification and/or stress-relief programs.

We recommend starting with one or more basic therapies using the bandpass technology before beginning with the allergy therapy. If necessary, individually tested subsequent therapies can be additionally administered.

Besides skillful and differentiated application of bioresonance therapy, we consider it important to holistically **restore**, if not all, at least the most disturbed functions and regulatory disorders. Depending on knowledge and skill, the following may be applied:

- Intestinal cleansing
- Introduction of a healthy, wholesome diet
- Cleansing of mucous membranes (regulating symbiosis)
- Proficient homeopathic constitutional therapy

Psychological Factors

The significance of the role played by psychological factors within the context of allergy dilemma is known and undisputed. However, it is often overestimated. From the viewpoint of psychoanalysis even clear clinical

symptomatology such as hay fever is said to be due to disturbed relationships during early childhood. Not coping with these disturbances would create a situation in which the id would have had to defend itself against an allergen. *"The allergen would eventually become the primary caregiver during the period of his/her earliest experiences and that which was perceived as menacing"* (R. Matteis).

Anyone who treats allergies biophysically and experiences the daily effect of this completely uncomplicated therapy can hardly agree with these beliefs.

Nevertheless, no therapist who has even the slightest feel for a patient's problems as a whole would deny the influence of psychological factors on the clinical symptomatology of allergies. In any case, they act as destabilizing factors. That is to say, the same allergen may cause reactions of varying intensity in the same patient, depending upon the current state of mind of the individual. **Psychological tension**, **conflict situations**, **overtaxation**, **difficulties with family**, **school**, **job**, etc., may exacerbate the situation.

In times of mental and emotional harmony, happy and pleasant circumstances, the symptoms may subside or disappear completely despite allergen influence (e.g., improvement of neurodermatitis during a relaxing vacation despite extreme, prevalent allergen stress).

On a very different level is a fact that is always used as indisputable evidence for the psychogenic cause of allergic reactions. Here is a famous example: Looking at a photo of a horse initiates an asthma attack in a person allergic to horses. The explanation for this spectacular behavior certainly does not lie within the subject matter of allergy, but doubtlessly in each person's ability to develop **certain reflexes**. When seeing the photo, the person allergic to horses reacts in the same way as Pavlov's famous dog when seeing its food. Created by experience, a response is activated and causes a specific somatic reaction.

A patient's psychogenic self-impediment is a problem that necessitates a different assessment altogether. It appears occasionally and has the potential to be a genuine obstacle to therapy.

Even though the patient undergoes various therapeutic treatments, subconsciously he/she **does not actually want to recover.** This is a phenomenon which occurs more often than commonly assumed.

Depending on the patient's psychological constitution, his/her life history, and the character of the illness, it may appear during any stage of an illness. It can be of a temporary nature and of no consequence, for example if the illness is a welcomed excuse to avoid dealing with personal problems.

In the case of chronic diseases with intense suffering, psychological self-impediment may turn into a pivotal problem that can forestall any therapeutic effort right from the start.

Besides the primary allergen that causes the allergy, chronic allergies and ensuing **allergic diseases** such as neurodermatitis, chronic bronchial asthma, and the various forms of colitis are almost always constructed upon a complex psychological foundation.

The longer the illness has been present, the more the psychological aspect will be involved in the illness until it dominates it—or so it seems. Many theorems regarding the psychogenic cause of the clinical symptomatology of allergies use this fact as their cornerstone.

Too much attention from the family, in many cases of chronic allergies, causes complex, highly ambivalent, partially conscious, largely unconscious intrapsychological tendencies and habitual patterns.

In particular, ambivalence towards the primary caregiver—mother, father, spouse—can take on strange manifestations. Rebelling against the illness, excessive overprotection, although initially considered necessary, eventually becomes untenable and may lead to self-destructive tendencies. It may also lead to the desire to punish the primary caregiver.

Naturally, these patients consciously long to recover at some point. That is why they consult with one or many physicians, therapists, faith healers, etc. However, their subconscious resists any opportunity of improving the situation or being healed. The more hope there is of finally succeeding, the more resistance the subconscious will offer. When therapy provides justified hope of genuine healing, the phenomenon of self-impediment is particularly obvious. Real psychological self-impediment rarely occurs in children. Dealing with the complex intrapsychological conflict commonly takes several years until it manifests externally. It may present in infants in rare cases. Often in this case, a neuropathic constitution of the child coincides with a particularly complicated family dynamic.

Example: patient E. C., born in 1989

Localized neurodermatitis appeared primarily on the face and in the bends of the joints. The infant was weaned after the eighth week. We started treating the child at the age of 2 years. We simultaneously diagnosed a cow's milk allergy and candida mycosis of the intestine, which we treated appropriately (avoiding the allergen, intestinal cleansing, allergy therapy). Initially, the skin condition improved. Then the child began to scratch excessively (more or less independently of the skin condition). Further progression was characterized by the following behavior: As soon as the skin improved a little bit, the child started scratching until it bled excessively (Fig. 7.17). Eventually we determined that there was a lot of tension in the family. A dominant grandmother competed with the mother, a somewhat weaker personality. Their mutual blame for the child's illness usually played a big role in their arguments. Family therapy was

Fig. 7.17 Cow's milk neurodermatitis unchanged. Complex family dynamics with a highly ambivalent relationship towards the mother causes resistance to the therapy. In the foreground are the effects of the child's scratching; their severity bears no relationship to the severity of the illness.

rejected. Numerous other treatment attempts by various faith healers also failed.

Achievements of Biophysical Allergy Therapy

Post therapy, for the patient who is only too familiar with the effect of his/her allergen, it is almost a miracle that the patient can tolerate a substance without reacting to it even though it has been bothersome, even life-threatening to him/her. No further evidence is required.

In the meantime, we have had experiences with many more than 1000 such patients. All of them have experienced the complete elimination of their allergies, in whatever way they may have expressed themselves. Our colleagues, physicians, and naturopaths have learned the methodology in our

seminars. Some of them have been applying it successfully in their practices for several years.

The statistics are hard to come by. However, feedback we have received informs us that the methodology is being practiced successfully in other locations.

Regardless of our personal experiences, the necessity arose, at least in the beginning of this development, to submit **statistics.**

It is always difficult to find acceptance for a completely new therapy modality. Prejudices and disbelief in all fields of science, including medicine, even at this juncture, still seem impossible to eradicate.

We wanted to attempt this, partially as a means to gain an overview of our therapy results. For a **statistical study** designed in 1989 and 1990, we used the popular methodology at the time: allergy therapy with program 999 coupled with strict avoidance of the allergen. The results were published in 1991. Only the most important details are summarized here.

We **selected the patients** as follows: **All** patients who received allergy treatments in our practice within a 6-month period were recorded on a list, independent of age, diagnosis, severity of symptomatology or type of allergen. A **definite allergen diagnosis** was necessary in order to be included in the study. Clear, positive proof of one or several allergy tests had to be provided (as previously mentioned, we prefer the allergen resonance test). In addition, in every case, the correlation between allergen and allergic reaction (e.g., skin rash, cough, bronchial spasm) had to be proven. Evidence was solid that strict avoidance of the allergen led to a significant improvement or complete disappearance of the symptoms. In many cases, the same held true for the opposite (within the context of an unwanted provocation).

All patients underwent uniform and exclusive biophysical **allergy therapy using the inverted frequencies of the allergens** (BICOM program 999). Strict avoidance of the allergen with zero margin for error was mandatory to begin the therapy.

Upon concluding the therapy series and a negative allergy test result (positive prior to the therapy), the patient no longer had to avoid contact with the relevant substance. He/she was instructed to report any subsequent recurring allergic symptoms. We questioned all patients in a **survey** about any side effects experienced, their progress after completion of the therapy series, any relapses that may have occurred, and finally their **overall assessment of the success of the therapy**. The survey was conducted 5 months after completion of the previously mentioned patient list, which had been kept over a period of 6 months. The period between the end of the therapy and the survey encompassed a minimum of 5 to a maximum of 11 months.

If the same patient was treated for **several allergens** during the period of the survey, the patient received a separate questionnaire for each treated

allergen. Each therapy series represented a case by itself and was individually assessed by the patient. This study recorded **164 patients with 204 case histories**. Out of the 204 questionnaires we sent out, 200 were returned (**a return rate of 98 %**!). We did not select the patients according to their clinical symptoms. Rather they were patients who happened to have received allergy therapies within a period of 6 months. As expected, we found that most of the allergic manifestations occurred on the **skin** (skin rashes, eczema, neurodermatitis), followed by **inhalation allergies** such as asthma, spastic bronchitis, persistent cough, etc.

The allergens that occurred most frequently were associated with substances with which we usually come into daily contact in our society: Wheat and cow's milk lead the food groups. Interestingly enough, they are followed by chemical additives such as azo dyes and preservatives (likewise already part of our daily food). In the case of inhalation of allergens, **goose down** was the most prominent. This goes along with our population's common use of down comforters and pillows. The house dust mite antigen, however, appeared in our statistic only once. Later we will discuss the distinct differences between our study and traditionally published allergy studies.

Due to its specific particularities, **hay fever** was excluded from this statistic. We researched it in a separate study, which will be discussed in Part II.

After concluding the therapy series, each patient underwent another **allergen resonance test for control purposes**. They all returned negative results.

We intentionally left it up to the patients to **assess the therapy's success**. Six months after concluding the therapy, we questioned the patient (and/or the family) in detail. The following responses were available:

- The allergy is eliminated. Previously observed allergic reactions no longer occur despite contact with the allergen.
- The allergy has improved. The symptoms are still apparent, but significantly diminished.
- The allergy continues unchanged. No therapy success is evident.
- A relapse has occurred. After initial elimination, the allergy to the same allergen has reoccurred.
- Cannot currently assess the therapy success as, for example, contact with the allergen has not occurred.

The evaluation of the patients' responses is illustrated in Figure 7.18.

Let us recap the situation that a patient suffering from allergies, as well as a physician treating allergies, is usually confronted with these days. The statement by the German immunologist, Müller, is still valid. He postulated that a true cure for an allergy (meaning lasting immunological tolerance to

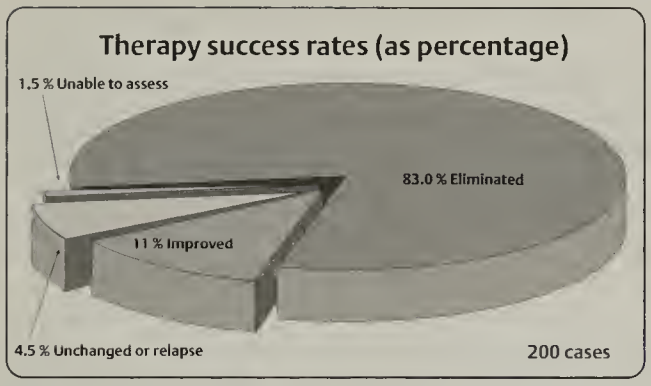

Fig. 7.18 Results of the study published in 1991 illustrating the effect of biophysical allergy therapy. More than 80% of the treated patients experienced absolute allergen tolerance after the therapy was concluded. In the long run the allergen was tolerated without any limitations.
Therapy failure in 4.5% of the cases was exclusively traced back to patient errors. The patients failed to strictly avoid the allergen during the therapy phase.
With regards to insect bite allergies, the response "unable to assess" signifies that during the time period of assessment the patients did not come into contact with the allergen.

the relevant allergen) **to date has not been achieved by any therapeutic modality!**

We believe that our results prove that this goal is indeed attainable. In any case, a success rate of more than 80% (true **healing success rate**) speaks for itself. A more detailed analysis of the individual cases yielded an even higher success rate than the superficial assessment of the questionnaires.

An analysis of the 22 cases that assessed the success of the therapy as "**improved**" shows that in almost all cases **misinterpretation** of symptoms had occurred that were only indirectly associated with the treated allergy.

The largest group of these 22 cases was eight patients with neurodermatitis. The allergy-induced neurodermatitis was healed, and they were able to tolerate the allergen again without reacting to it (clear therapy success). However, the parts of the skin previously afflicted with neurodermatitis still showed **residual mycoses**. (The term residual mycosis will be discussed in detail in the chapter on neurodermatitis in Part II.) It is only correct to use the term residual mycosis within a particular context—when the cause of the neurodermatitis is truly eliminated. Anyone who does not recognize the correlations believes that the neurodermatitis continues to exist at low levels, particularly since the focal fungi are commonly localized in the areas

primarily affected by neurodermatitis (bends of the joints, neck, hands, etc.).

During follow-up, five patients of the group were classified as "**allergy improved.**" It turned out that **unspecific symptoms had been confused with allergy-related manifestations.** This confusion applied in particular to an unspecific infectious cough in asthma patients whose allergy component had been eliminated, and to occasional unspecific stomachaches occurring after healed allergic colitis.

We found similar mistakes with four other patients of this group. All of them had multiple allergies. After eliminating one allergy mechanism, there were still residual **symptoms of the untreated allergies.**

Following successful elimination therapy, all patients were able to tolerate the respective allergen without any restrictions or reactions to it. Only four patients (2%) showed continued **quantity-dependent intolerance** of this substance, but this never led to a true relapse.

The **true relapses after therapy was concluded** (seven cases = 3.5%) are easily analyzed: When questioned, in each individual case, the patient did not strictly avoid contact with the allergen during therapy. There may have been occasional contact with the cat or guinea pig or cake was surreptitiously eaten, etc.

There were two cases in which **therapy failed**, that is to say, the allergy symptomatology continued unchanged after conclusion of the therapy. In both cases we established that a **consistent error during the therapy phase** was the cause of failure.

We were delighted that **not one single failure was due to misdiagnosis of the allergen**! In our opinion this confirms our concept of diagnosis and adhering to the strict criteria prior to elimination therapy.

Taking all circumstances into consideration, the **true success rate is above 90%.** This is unheard of for a therapy statistic and hard to believe; however, the case studies clearly document and support it.

As we had expected, the study, published in 1991, caused controversy. It found broad acceptance among proponents of bioresonance therapy and similar methods. The study even received a research prize.

Understandably, allopathic medicine reacted negatively. If it was noted at all, the comments on the study ranged from "*unbelievable*" to "*unusable*" *as well as* "*pure deception.*" One professor of medicine relegated the methodology to the field of semeiotics. Somebody else chose to state: "*The methodology is speculation and deceives the patient. Its methods are based on mystical principles (illnesses are supposedly created by the patient's own electromagnetic oscillations).*"

At times the accusation is made that the patients are given false hope and that there is no statistical evidence regarding the methodology's effective-

ness; also, that there is no data to indicate "*how electromagnetic oscillations are recorded and inverted,*" etc.

"Scientific medicine" is based on two fundamental ideas:

- A new thought modality is only accepted if it fits perfectly into the traditional paradigm, else it is not worth the time and effort to pursue it.
- Statistical documentation that does not conform exactly to the strictly accepted "rules of science" will not even be considered from the outset, even if it deals with phenomena, so far unknown to medicine, that warrants other criteria for evaluation.

At least some universities have recently started to research the phenomenon of biophysical therapy of allergies, designing comparative studies—on the one hand allopathic allergology, on the other biophysical methodologies.

Interestingly, this happens exclusively in places where qualified colleagues apply the methodology successfully. It seems that the (healed) patients exert a certain pressure on the public, health insurance providers, and finally university institutions.

These rudimentary attempts, as welcome as they are in themselves, cause some concerns that are primarily predicated upon the **fundamental differences of both methodologies**.

Each clinical scientific study must set the criteria by which the patient selection will occur. In the case of a comparative allergy study, the criteria would be an allergy diagnosis that delivers relevant results for both therapeutic methodologies.

The final outcome was (and clinical allergologists are aware of this) that classic clinical test methodologies are somewhat unreliable. This applies to many areas, particularly food allergies.

A statistical comparison to the biophysically diagnostic methodologies appears futile as long as it cannot be proven which of the two statements is de facto correct in the case of divergent results.

Avoiding discussion of the relevancy of the diverse diagnostic methodologies may require limiting the study to patients who know their allergy solely from their own experience (not based on any kind of tests). (For example: asthma reaction to and/or after each contact with cats, horses, guinea pigs, etc., or itching skin rash after ingesting specific food or pharmaceuticals, etc.)

These types of acute allergies occur frequently. Even though they may be prevented by mindful avoidance of the allergen, their actual cause is only rarely treated.

By eliminating the allergy as illustrated (positive therapy result), bioresonance therapy can prove that its diagnosis was correct. For this reason every comparative study should always include a therapy study.

The criteria applied to assess the success of the therapy should be exclusive **evidence of allergen tolerance after conclusion of the therapy**. **Allergen provocation** would easily provide this proof.

We would like to emphasize one more time that the behavior of immunological tests, after conclusion of biophysical allergy therapy, is a fact that continuously leads to misunderstandings:

> Biophysical allergy therapy does not influence immunological tests. Prick or RAST test results that were positive prior to therapy will usually remain positive after the conclusion of therapy, even though the patient no longer displays any symptoms and tolerates the relevant substance now and in the future.

This discrepancy continues to place patients in a state of uncertainty. A much repeated situation that people experience is the following: A physician, who does not believe in the methodology, as he/she is unfamiliar with it, wants to prove to a patient that, from the viewpoint of allopathic medicine, the therapy conducted by a colleague is completely ineffective and indeed "clever fraud" or something to that effect. Even the patient's repeated affirmations that the allergy has completely disappeared and that he/she no longer experiences any reactions to the allergen, often does not convince the skeptical colleague. Catchphrases like "placebo effect" or "tendency to spontaneous healing" are the arguments used to support the physician's view (primarily for the physician's peace of mind).

The behavior of immunological tests is no surprise to anyone familiar with the methodology. Biochemical immunological processes are much slower than those regulated biophysically on the informational level. Besides, many examples illustrate that the occurrence of specific IgE antibodies is not at all clear proof of a relevant clinical allergic response to this substance.

The issue of **false-positive immunological allergy tests** was already mentioned and we will continue to discuss it.

> To date, the true elimination of an allergy, i. e. reestablishing unlimited allergen tolerance, is unknown to medicine.

This new and unique situation should be considered in any statistical analysis. Asking the simple question whether bioresonance therapy is indeed

able to eliminate allergies as it claims, the response to the question should simply be **yes** or **no**.

Steps necessary to determine an **improvement ratio**—a normal procedure in therapy studies—and their statistical significance compared to a control group, would be an unnecessary task, time-consuming and not cost effective.

Young scientists, looking towards the future, may be well advised to do some pioneering work in this field. They may turn out to be at the pinnacle of a new branch of science, which potentially could become extraordinarily fruitful.

Part II: Allergies—Clinical Studies

8 Hay Fever

Epidemiology

Allergies to pollen are certainly the most frequent and significant form of allergies worldwide. Depending on the area and the species of plants, 0.5 to 10% and above of the total population experience hay fever. Millions of people are affected annually.

General observations show that allergic diseases have steadily increased over the past 10 to 20 years, among them, pollen allergies. According to the German Association for Persons with Allergies (Allergikerbund), in Germany alone an increase in excess of 150% was recorded within the past 20 years. The Austrian Bureau of Statistics reports that allergies among 18-year olds have tripled in Austria since 1985!

Many stressors in our daily lives have caused the overextension of the adaptation mechanisms of the human organism. This may play a significant role in the rise of allergies.

These days, with regard to pollinosis, **adjuvant effects of air pollution** are discussed more frequently. It appears that pollens combined with pollutant particulates have the ability to change their antigenicity, becoming more aggressive (Behrendt 1991, Voigtländer 1991). Cigarette smoke in apartments, public transportation, etc. may have a similar effect.

According to numerous statistics, until approximately 15 years ago people living in the city in Austria would generally fall ill 15 to 20 times more often than the average population. However, in recent years the rural population has become increasingly affected, balancing the morbidity numbers to a large degree. The ubiquitous presence of pollution today may be responsible for this development. Even people in rural settings no longer live healthily on a secluded island. They have adopted the habits of urbanites, purchasing their groceries in supermarkets, for example. Air pollution has been a problem for many years.

In recent years, the **morbidity rate has increased.** More and more younger children and, in particular, people above 40 years of age are falling ill.

Even though the average population of a particular area is exposed to the same allergens, only a certain percentage is affected. **Genetic predisposition** is the general basis for the tendency to develop allergies. In the first part of this book, we already discussed the technical term "atopy" to explain the familial aspect of allergic symptomatology.

Almost all pollinosis patients are atopics. Their relatives and family frequently display allergy symptoms. The patients themselves often suffer

from additional diseases related to atopic maladies such as asthma and neurodermatitis.

Compared to other allergic diseases, hay fever displays some special characteristics listed below:

Particularities of Pollinosis within the General Context of Allergy

1. Strictly **seasonal occurrence** is dependent upon the flowering of respective plants.
2. During pollen season **avoidance of the allergen to the point of isolation is hardly possible.**
3. **Multiple allergens** cause identical clinical symptomatology.
4. Critically dependent upon **time of day** (in the mornings pollen emission is at its highest) and **meteorological factors** (wind, sun, rain, fog inversion, etc.).
5. The allergen's original location may be distant. **Pollen** may be airborne for several hundred miles and as high as 3.1 miles (5000 meters!).
6. **Air pollution** may exacerbate the role of pollen, making it more aggressive!
7. The **morbidity curve** begins at about 5 years of age, is at its highest level during the 20–30-year period, and decreases after the age of 40.

Symptomatology

The clinical symptomatology of hay fever is well known and characteristic: Itching of the nose and eyes (occasional itching in the throat and auditory canals), sneezing, fluid discharge, alternating with periods of nasal obstruction caused by nasal mucosa edema. Eye symptoms may dominate. They can range from simple conjunctivitis to extreme gelatinous edematous swelling of the conjunctiva, and anything in between. Concurrent general symptoms are frequent. Many patients complain about decreased performance, headaches, and chills. Children's performance in school is often significantly impaired. They tend to be chronically tired, inattentive, and periodically become noticeably hyperactive.

Besides nasal mucous membrane and ocular conjunctiva, other mucous membranes may be affected. First and foremost among them are the **respiratory tracts**: Preceding hay fever, infants often display seasonal allergic tracheitis concurrent with pseudocroup-type symptoms. In later years, an increase in the spastic element is often seen in allergic bronchitis, which may eventually develop into true **pollen asthma.** In older patients the nose as the primary site of reaction may "fall silent" while asthma persists as the

only manifestation of the reaction. In rare cases **urticaria** and **Quincke's edema** as well as enteritis may occur as a consequence of the absorption of pollen in the respiratory or digestive tracts. During pollen season neurodermatitis is often more acute. Allergic mucous membrane symptoms are usually acute during exposure to pollen. Besides the immediate reaction many patients also experience an allergic infectious **delayed reaction** (see Fig. 10.1). It often causes problems at night when there is no exposure to pollen at all. Frequently, an **increased susceptibility of the affected mucous membranes** results from pollinosis. The mucous secretion subsequently thickens. Sinusitis and otitis are the resultant conditions.

Etiology

Hay fever is not only one of the most common, but also the best-known allergy. Everyone knows what is meant by hay fever. Yet few people have the necessary botanical knowledge to really understand the interrelations. This may also apply to physicians and therapists who have had many professional dealings with hay fever. To fill in any existing gaps in knowledge, we would like to digress into palynology (the study of pollen) and botany:

Pollen carries the male gene in higher-level plants. Pollen production takes place in the pollen sacs of the flower. From there they are released and transferred to the stigma of the respective plant through the air (**pollination via wind** = anemophily) or via **insects** (entomophily). Allergic substances come from the cytoplasm of pollen. They are released as soon as there is contact with water, which produces subsequent swelling (of the moist stigma, but also when in contact with the mucous membrane of a human being).

Innumerable amounts of pollen are produced (a single ear of rye, for example, produces more than 4 million pollen!). The pollen of wind-pollinated plants is very light and small: 20–50 µm. It travels for several hundred miles, at altitudes of 3.1 miles (5000 m!).

On a typical "pollen day" the daily ventilation quota (i. e., the amount of pollen inhaled) ranges from several to many thousands of pollen grains. In someone sensitive to pollen, between 5 and 50 "sticky" pollen grains may trigger pollinosis symptoms. Among the thousands of plants producing pollen, less than 100 possess the ability to trigger pollinosis. For a plant to act as a hay fever agent, certain criteria have to be met (as postulated by Thommen, see boxed text).

Thommen postulate

1. The plant must be part of the species of **wind-pollinated** plants (linden and willow trees are the exception as they belong to a few plants that are pollinated by wind as well as insects [ambophily]).
2. A large **amount of pollen must be released.** (Usually the case for wind-pollinated plants.)
3. The plant must spread across **large areas of land**. (Grasses by themselves account for three-fifths of all plants on earth.)
4. The pollen must be **light** and airborne, able to be carried long distances by the wind.
5. The pollen must contain a **strong sensitizing antigen**. Excessive accumulation in the air is insufficient (e. g., fir and pine pollen).

In Europe, the various grass types (gramineae) meet all the criteria listed above. Subsequently, **allergies to grasses are the most frequent type of pollinosis in Europe**.

Ever since we have been able to exactly diagnose pollen allergies by means of physical methodologies, certain aspects have been emphasized that do not correlate in every detail with lists published to date.

With regard to hay fever, twelve types of grasses have turned out to be particularly important among the many grasses prevalent in Europe. Their pollen may account for more than 95% of all grass pollinosis (typical predominate irritation season is May/June). According to our data, they are compiled below in order of importance:

The 12 Most Important Grasses

- Bentgrass *(Agrostis tenuis)*
- Kentucky blue grass *(Poa pratensis)*
- Dog's-tail grass *(Cynosurus cristatus)*
- Orchard grass *(Dactylis glomerata)*
- Sweet vernal grass *(Anthoxanthum odoratum)*
- Herd's grass *(Phleum pratensis)*
- Meadow foxtail grass *(Alopecurus pratensis)*
- Tall oat grass *(Arrhenatherum elatius)*
- Velvet grass *(Holcus lanatus)*
- Rye grass *(Lolium perenne)*
- Meadow fescue *(Festuca pratensis)*
- Soft chess *(Bromus mollis)*

The individual grasses are illustrated in black and white in Figure 8.1 Most people know what they look like. Yet, hardly anyone knows their botanical or common names. If a patient tests positive to bentgrass, he/she may be unaware that the plant is growing plentifully outside their window. Even though we are now able to eliminate pollen allergies quickly and long-term, it remains beneficial to educate the patient with a picture of his/her pollen plant.

The second most important group of plants, after grasses, is **early blooming trees and shrubs**. In mild winters, hazel, alder, and willow start blooming as early as January and/or February. Birches may bloom well into April. Some of them are ambophily plants (wind/insect pollination) as, for example, the various willows. Yet, their pollen meets all the criteria for triggering pollinosis: It is produced in large amounts, is light, easily airborne, and strongly antigenic.

Among them only a few are responsible for the early onset of pollinosis (as previously mentioned, hazel, alder, willow, and birch). As a botanical refresher, pictures of those plants in bloom are displayed in Figure 8.2.

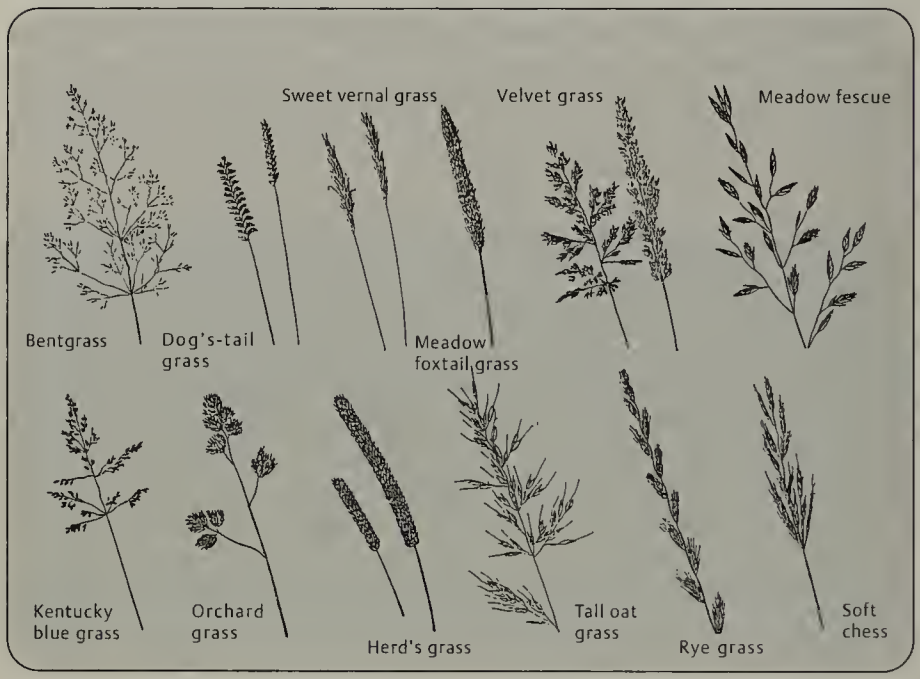

Fig. 8.1 The twelve most important grasses. Their pollen may trigger more than 95% of all grass pollinosis (highest incidences May/June).

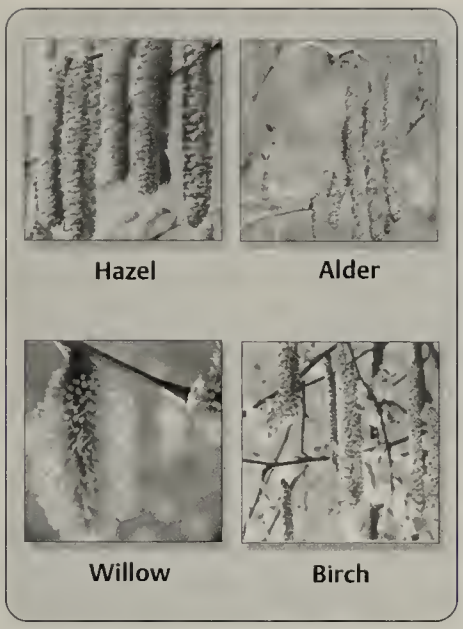

Fig. 8.2 The four most important early bloomers. Pollinosis occurring as early as January to March is mostly triggered by pollen from hazel, willow, and alder. Birch pollen is the main hay fever trigger in March and April.

Rye is the most important plant among grain pollen, which plays a significant role in all agricultural areas as a trigger of pollinosis. Its pollen contains extremely aggressive antigens and is produced in unbelievable amounts (4 million pollen in one single ear of rye at the height of the blooming period!).

It may be due to this specificity that we have observed similar occurrences with rye antigens as with house dust mite antigens. For example, many people develop specific antibodies, yet few of those sensitized actually display allergy symptoms when they come into contact with rye pollen. In other words, not everyone with positive skin or blood-testing results to rye pollen automatically has a relevant rye allergy. We know a great number of patients who have never had hay fever symptoms even though routine tests regularly found antibodies to rye pollen.

Besides grasses, early blooming trees, shrubs, and grain, there is a group of **weeds** whose pollen quite frequently leads to hay fever symptoms, specifically in late summer and fall.

Besides the stinging nettle (*Urtica dioica*) and pellitory (*Parietaria judaica and Parietaria officinalis*), the **common mugwort** (*Artemesia vulgaris*) and **pigweed** (*Chenopodium album*) trigger hay fever symptoms. Mugwort and pigweed primarily grow on uncultivated land, along the perimeter of pastures, embankments, landfills, etc. They grow almost 6 ft (1.82 m) in height

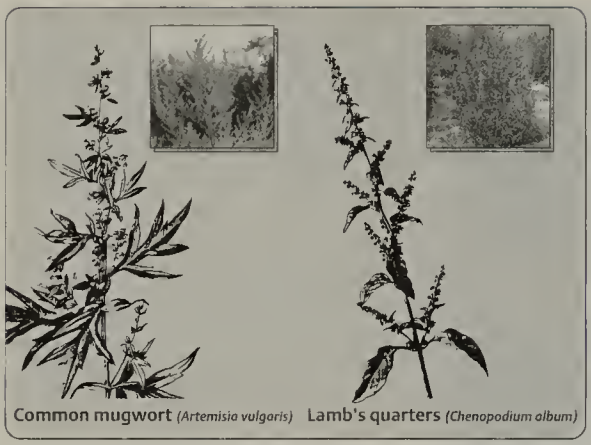

Fig. 8.3 Common mugwort (*Artemesia vulgaris*) and lamb's quarters (*Chenopodium album*). Their pollen quite frequently triggers pollinosis in late summer.

and their flowers are inconspicuous, as is common for wind-pollinated plants (Fig. 8.3).

Located primarily in the US, **ragweed** (*Ambrosia elatior*) only recently gained importance in Europe. It will certainly continue to engage us in the future (Fig. 8.4).

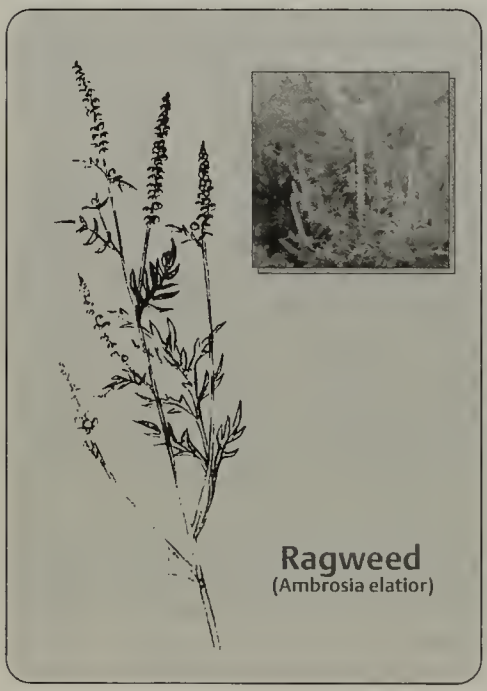

Fig. 8.4 Ragweed (*Ambrosia elatior*) is a weed that blooms in the fall. Its pollen is an important hay fever trigger, particularly in the United States. Recently the plant has started to establish itself in Europe.

Just like common mugwort and lamb's quarters, ragweed blooms in the fall, grows on fallow land and waste management sites, etc. It is strongly allergenic. Millions of people suffer from "ragweed fever" in the United States each year. In recent years, the plant seems to have become increasingly established in Europe (northern Germany, Hungary). Particularly noticeable in the United States is the fact that many people who usually do not suffer from allergies are affected exclusively by a mono-allergy to ragweed. Every occurrence of hay fever that begins in September or lasts into the fall should definitely be tested for ragweed allergy.

According to accepted statistics, the previously mentioned and illustrated 20 plants are the most common triggers for hay fever in northern Central Europe. Other climatic zones, for example the Mediterranean, have other primary allergen triggers which are not mentioned here.

Besides the primary plants we listed, there are a large number of pollen producers that are not mentioned, yet may play a role for individual patients. In areas with deciduous forests, for example, the pollen of various deciduous trees is more prominent. In primarily pastureland and grassland areas, grasses dominate.

Well-known pollen flight calendars (Fig. 8.5) present an overview of when specific plants bloom. Pollen alert services, active in most areas in Central Europe, provide information to people suffering from hay fever.

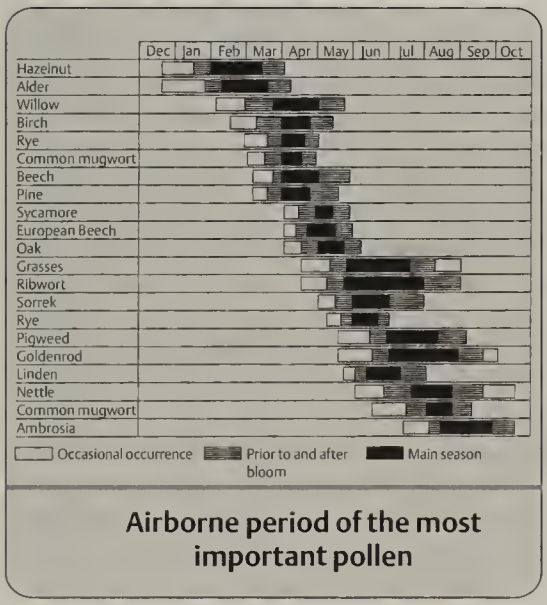

Fig. 8.5 Times and duration of pollen flight in Central Europe.

Pollen of **coniferous trees**, in particular from spruce and pine, is often underestimated. Some years pollen emission is so high that dense pollen clouds hover over forests for many days. The entire countryside is covered with a thin layer of yellow dust. After heavy rains, pollen floating in streams and bodies of water form a yellow film on the surface.

These incredible amounts of pollen may cause sensitive people to experience an irritation of the mucous membrane. This is primarily a mechanical irritation; it is rarely a true allergic reaction.

The pollen of most coniferous trees, particularly spruce and pine, is mildly allergenic. Only in rare instances do these species cause symptoms of true pollinosis. Due to their spectacular and numerous appearance, patients often suspect they are the cause of the symptoms rather than an unobtrusive grass blooming at the same time.

Similar observations have been made by patients on **flowering plants**. All flowering plants (flowers, shrubs with blossoms, fruit trees, etc.) are insect-pollinated. By means of color and smell, blossoms fulfill their primary function: to attract the necessary insects for fertilization. Contrary to pollen of wind-pollinated plants (light and airborne), their pollen has completely different properties. It is heavy and sticky to ensure adherence to the insect. Accordingly, true hay fever symptoms as a consequence of an allergy to flowering plants are extremely rare. Contact allergies, however, do occur when contact is made with the relevant plants. Moreover, professionals likely to be exposed to plants (e. g., farmers, gardeners, and florists) may typically develop a persistent summer dermatitis that manifests on exposed areas of the body (face, neck, hands, forearms). The plant family of composite flowers is generally considered to be particularly allergenic. Among them are plants used in naturopathy and natural cosmetics, for example camomile or arnica. Many flowering plants bloom at the same time as grasses. Unaware of complex botanical interrelations, a great number of hay fever patients are convinced that colorful flowers, blooming shrubs, or fruit trees are the cause of their suffering. (Hay fever was already known in the Middle Ages, but incorrectly diagnosed; people called it rose fever.)

To prove these patients wrong, we had to add a variety of pollen from flowering plants to the pollen test set. Here, too, inconspicuous grasses blooming at the same time are the actual causes of the allergy. However, we need the negative test results of the accused flowering plants' antigens to convince patients of the true interconnections.

For people with pollen allergies, **meteorological factors** play a particular role in terms of exposure and the subsequent changing symptomatology. The amount of rain fall, for example, influences pollen counts as rain clears the air. Fog formation, on the other hand, coupled with inversion frequently leads to extremely high pollen concentration at ground level. Sunny weath-

er with temperatures in the upper moderate range considerably increases the plants' pollen emission. The early morning hours are the peak times of pollen emission (hay fever is worse in the mornings).

The strength and direction of the wind are important factors for some pollinosis patients. Ever since we have been able to eliminate pollinosis biophysically, we have observed that mild symptoms of the prevalent grass allergies remain post-treatment. Interestingly, they occur episodically according to certain types of wind situations. We believe that in these cases rare pollen (often unidentifiable by testing) is blown in as clusters from great distances. These patients can walk through a blooming pasture without having any reaction. They will only display symptoms if they get caught in a pollen cloud blown in on the wind that still contains allergens relevant for them.

Therapy

As mentioned, pollinosis is the most frequent, economically significant allergy disease. For this reason, a myriad of therapeutic applications exist. Some make sense, others do not.

True avoidance of an allergen to the point of isolation is almost impossible during pollen season. Using a variety of **technical measures** (filters, ionisation devices, etc.), people try to reduce exposure to pollen but it seldom leads to significant relief.

There are also numerous efforts to change the patient's own susceptibility to react. Using a **psychological approach** as well as **dietary measures**, physicians attempt to achieve a general change that will alter the susceptibility to allergies.

Today almost every hay fever patient takes some kind of **pharmaceutical** (from antihistamines, mast cell stabilizers such as DNCG, etc., to high dosages of corticoids in long-term therapies). In all cases, symptoms are merely suppressed. It is a "bandaid" therapy that does not address the source of the allergy.

Practiced worldwide by millions of people, clinical allergologists generally recommend **hyposensitization**, a specific immunotherapy. Even though hyposensitization addresses the cause, we believe that it is **only justified as long as there are no other effective, less dangerous methods available**. The therapy calls for regular injections, administered consistently over several years, whereby the allergen dosages are gradually increased. This is highly stressful for the patient (as well as the physician). It is also quite risky as it could lead to a possibly life-threatening anaphylactic reaction.

The oral methodology, whereby the dosage of allergen drops administered is gradually increased, has proven completely ineffective (Wahn 1987).

We have to distinguish hyposensitization from **antisensitization**, a methodology developed by Theurer. At times it leads to successful results just like the other variants of **treatment with the patient's own blood**. Other common treatments such as **homeopathy, acupuncture, and neurotherapy** are often administered successfully.

The diversity of therapy approaches shows that the best possible methodology has yet to be discovered.

Biophysical Therapy of Hay Fever

Hay fever, a classical Type I allergy, is very suitable for biophysical treatment. Even though the introduction of new therapy approaches have considerably facilitated, in particular, pollinosis therapy, there are some peculiarities that require attention.

Therapy Using Inverse Oscillation and Avoidance of the Allergen (Program 999)

We (and many other therapists) routinely used this therapy form until 1992. Due to problems of avoiding the allergen, treatment was only possible during pollen off-season, in the winter months.

At that time the patient also had to avoid any contact with hay (stables, barns, pets living in hay or eating hay, etc.).

If the patient followed all the rules, results were good. In general, the **large number of possible allergens** have caused problems to date for all types of hay fever therapies. Experiences in recent years have shown how important it is to diagnose all allergenic pollen for a particular patient, taking it into account during therapy.

The use of **combined antigens** presented an additional problem. At the time, they were thought to be indispensible and were used to specifically treat patients suffering from numerous pollen allergies. For economic reasons and in the interest of time, in the winter of 1989/90 we treated approximately 130 patients suffering from wild grasses allergies with a mix of six grass pollen allergens (tall oat grass, orchard grass, meadow fescue, rye grass, herd's grass, and Kentucky blue grass). We assumed we had the most significant grass types covered (according to allergological literature).

However, more than half of these patients continued to report pollinosis symptoms while the grasses were blooming the following summer. The symptoms were considerably milder than in previous years. Yet, the allergy

was not completely eliminated in those patients as it had been for the other half.

Further testing of the group in which therapy had failed revealed negative test results in all cases for the treated allergens. At the same time test results were positive for one or several grasses not included in the therapy combination (see boxed text).

The following **additional pollen antigens** were discovered in 44 patients following treatment with a combination of six grasses that resulted in unsatisfactory therapy success:

Bentgrass	30×	
Dog's tail grass	17×	
Sweet vernal grass	24×	
Meadow foxtail grass	4×	(Most patients were allergic to
Velvet grass	1×	two or more of these grasses.)

Based on these experiences, we made up a new list of the 12 most significant meadow grasses (see list on p. 115).

We created one **combined antigen** from the pollen antigens of these 12 grasses. Beginning in the summer of 1990, it was added to the basic test sets and we used it routinely during the 1991 pollen season to treat all meadow grass allergies. Analyzing the treatment results of that season resulted in new and important realizations in optimizing pollinosis therapy.

Therapy Results in 1991

From November 1990 to April 1991 we treated 115 patients suffering from pollen allergies in the manner described in the previous section (inverted oscillation using program 999). Two allergies to different pollens were treated separately in 24 patients within the group of 115. Two patients were treated for three different pollen allergies, bringing the total of treatment cases to 145. Being in the pediatric field, our patients were primarily children. A little more than 25% were teenagers or adults. Most patients had experienced hay fever symptoms for several years. Accordingly, they had undergone several ineffective therapies prior to seeing us (22 patients reported unsuccessful hyposensitization therapy over the course of 2 or more years).

Figure 8.6 shows the types of allergens established by testing and used for treatment. As expected, allergies to various meadow grasses are predominant, followed by early bloomers such as alder, willow, and birch. Rye pollen was shown to be of relatively little importance in our data. Doubtlessly,

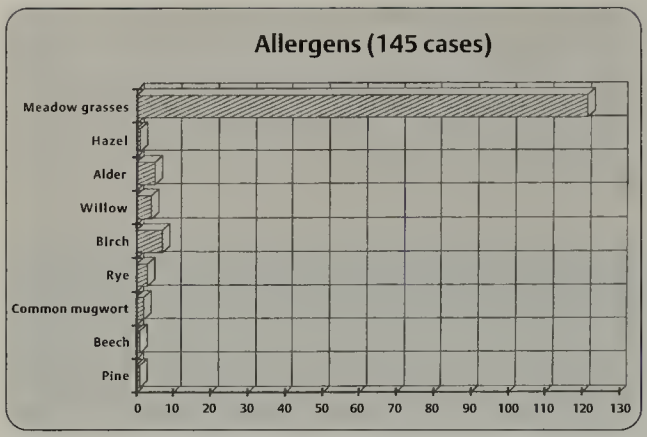

Fig. 8.6 Allergen distribution. In the Alps and foothills of the Alps, where most of our patients live, animal grazing, both pasture and alpine, are the predominant economies. This explains the noticeable prevalence of allergies to various meadow grasses followed by early bloomers such as alder, willow, and birch. An allergen list of patient data collected in central or northern Germany would show more emphasis on rye pollen, whilst a study in the Mediterranean regions would produce other results.

the reason for this is our geography coupled with the particularities of the flora in our mountainous region of Tyrol. The economy is primarily based on pasture/alpine grazing.

Rye is almost never cultivated in our valleys. In contrast to the flatlands where wind can carry pollen several hundred miles, it does not play a major role in mountainous terrain.

An allergen list of patient data collected in central or northern Germany would certainly paint a different picture. A study in the Mediterranean regions would yield its own unique blend of concentrations. In October 1991, after the pollen season ended, all patients were questioned as to the success of the therapy. The patients' responses (parents answered for their children) were categorized into four groups:

"**Eliminated**": No pollinosis symptoms appeared during the pollen season of 1991.

"**Significant improvement**": A few residual symptoms on certain days were recorded during the pollen season of 1991. Otherwise there were no symptoms.

"**Improvement**": The symptoms had improved compared to previous years. However, significant residual symptoms remained.

"**Unchanged**": Compared to previous years, pollinosis symptoms were just as strong in the season of 1991 (possibly even stronger).

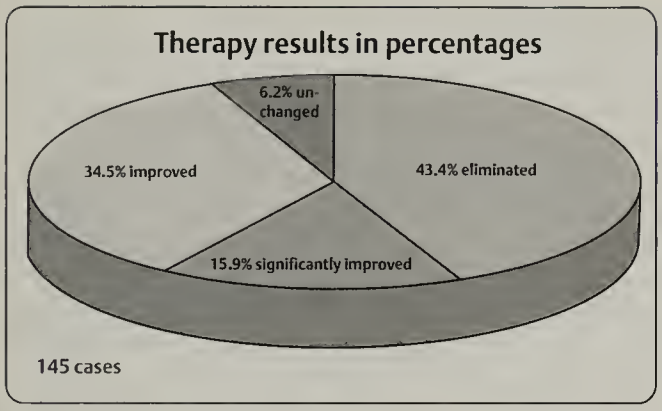

Fig. 8.7 Therapy results (pollinosis therapy 1991). During the following pollen season about 94% of the patients reported a noticeable improvement of hay fever symptoms. Yet, only 60% reported a significant improvement, ranging from elimination or reduction of symptoms to minor episodic complaints. Extending the diagnosis coupled with avoiding combined antigens may improve these results.

The results of this questionnaire are illustrated in Figure 8.7.

Adding together group 1 ("eliminated") and group 2 ("few residual symptoms") accounted for **60%** of the patients treated reporting a **satisfactory therapy** success. The remaining 40% must be considered a failure and briefly analyzed:

The easiest assessment was that of three patients who reported unchanged pollinosis symptoms. They admitted to more or less regular **contact with hay** during therapy (guinea pig cage next to the bed, frequent time spent in a stable while visiting a farmer's boy, time spent playing in a hay barn).

Not as easily analyzed were the interrelations of the other group, which was considered a failure. A comparison with the results of the general allergy study, discussed in detail in Part I, shows a success rate of almost 90%. This suggests that **pollinosis-specific factors** play a significant role. Two specific characteristics of pollinosis need to be considered in this case: The large number of allergens and the subsequent inevitable use of combined antigens for therapy.

The Problem of a Multitude of Allergens

Pollinosis is an allergy disease wherein numerous allergens may contribute to a uniform symptomatology. Physicians can never be assured that testing will find all pollen allergens relevant to a patient.

Even the experts, who are in charge of individual countries' pollen alert services, are occasionally confronted with a group of unidentifiable pollen. They may be allergenic; nevertheless, no preparations for diagnostic or therapeutic solutions exist.

Even the known and identifiable pollen allergens are so numerous that extraordinarily extensive, time-consuming testing would be necessary to ensure that all allergens in question have been addressed.

Therefore the process has to be economized. That is to say, we have to establish certain **reasonable restrictions**.

Currently we test each pollinosis patient for the early blooming shrubs and trees (hazel, willow, alder, and birch), the 12 most important meadow grasses (first using the combination of the basic test set; if the results are positive, we test all grasses individually). We test for the most important grain pollen, particularly rye and corn, and finally for the weeds mugwort and pigweed. This covers the most significant pollen antigens for the majority of patients. Based on this information we design a treatment plan for the upcoming pollen season. If the results in that season do not satisfy, we will extend the test spectrum considerably.

In order to be able to test these problematic patients, we have extended our own allergen collection to contain over 100 pollen allergens. Based on our experiences, we designed a test set specifically for pollen. (The book *Die Testsätze nach Dr. P. Schumacher* [Test Sets According to Dr. P. Schumacher] contains further information.)

This specific pollen test set also contains a number of pollen that by themselves hardly qualify as an allergen, for example, pollen of flowering plants exclusively pollinated by insects.

As previously mentioned we include this in our testing only if the patient, based on his/her own observations, attributes these kinds of pollen to be the source of his/her pollinosis symptoms. In this case we use a negative test result to prove the patient wrong.

Therapeutic Use of Combined Antigens

Experiences in treating other allergies have shown that reliable and long-term elimination of an allergy is only possible when therapy is **limited to one single allergen**. This applies to therapy with the inverted oscillation of the allergen as well as the methodology allowing contact with the allergen.

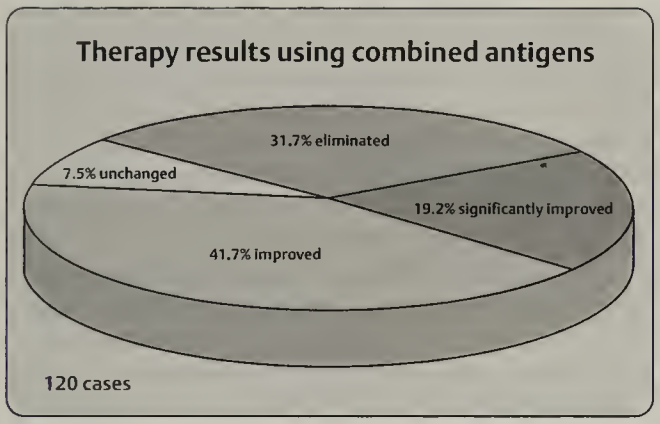

Fig. 8.8 The results of the 120 patients treated with combined antigens (exclusively allergens of meadow grasses) were considerably less favorable. The analysis shows that on average 50% of the patients reported unsatisfactory results.

As in other cases, the best therapy results for pollinosis are achieved if individual allergens are used for each therapy series.

A break down of our treatment results shows this clearly:

Twenty five cases, out of a total of 145, were treated with individual allergens. When questioned after the pollen season, all patients reported a complete elimination of the allergy.

The results of the 120 patients treated with combined antigens (exclusively allergens of meadow grasses) turned out to be considerably less favorable. Figure 8.8 illustrates that, on average, 50% reported unsatisfactory results.

Therapy Methods without Avoidance of the Allergen

The new methodologies that no longer require avoidance of the allergen considerably simplified procedures, particularly when treating hay fever. They can be applied during the pollen season when the patient experiences the symptoms. Consequently, considerably less therapy sessions are required.

Program 998 (increased amplification of the allergen information) as well as program 978 (therapy using frequency bandwidth 24 kHz) have proven effective.

Both methods are technically simplistic, requiring little time. Neither a knowledge of acupuncture nor an assistant is required. Therapy can begin immediately after the diagnosis has been established. Several allergies can be treated in one therapy session, one after the other. This is impressive with the patient experiencing the success of the therapy immediately. Moreover, deciding on a therapy using individual allergens or combined allergens has become much easier.

If possible, we tend to avoid testing multiple allergies in a given day. However, the possibility of eliminating three or more allergies immediately, one after the other, with such a simple method saves a lot of time and is much easier.

In recent years, pollinosis therapy has always been conducted during the winter months. Not until the end of the ensuing pollen season was it possible to review the data. For the first time, in the pollen season of 1993, we were able to directly experience and assess the treatment effect. We noticed that the therapy effect would usually be evident after the first, at the latest second therapy. In many cases pollinosis symptoms disappeared slowly. For several days the patient experienced a post infection. Swelling of the nasal mucous membrane was common as well as increased nasal discharge. It was no longer watery, but thick, often greenish-yellow and purulent. These mucous membrane symptoms, outlasting the real pollinosis symptoms by several days, are doubtlessly due to an infectious delayed reaction of the allergy. This mechanism, operating via various cells and mediators, occupies allergologists considerably at this time. We will discuss it further in the chapter Bronchial Asthma (see also Fig. 10.1). Also, it obviously seems to play a fairly significant role in the case of pollinosis. The delayed reaction will subside after 2 or 3 days at the most. As a result, the patient is symptom-free—if our allergen diagnosis was correct.

Persistent, typical, pollinosis symptoms subsequent to the conclusion of allergy therapy, indicate a diagnostic error. True misdiagnoses are rare for an experienced tester. Pollinosis is somewhat the exception due to the multitude of potential pollen allergens. Even when applying subtle test techniques and extensive test materials, it is sometimes impossible to expose all pollen allergens relevant to a particular patient. We already mentioned this aspect during the discussion of our study in 1991. Consequently, we extended our test data considerably. Despite these efforts we continue to experience cases resistant to therapy (solely with regard to meadow grass allergies). It simply does not seem possible to identify all allergens. Independent of our test results, in the summer of 1994, when dealing with allergies to grasses, we started to use **current pollen** for the therapy **from the area the patient resided in**. On a day with a high pollen count the patient is asked to rub a cotton swab firmly across a smooth, horizontal surface out-

doors. These cotton swabs are placed in an envelope or paper bag and brought to therapy. Window sills, balcony railings, as well as tin roofs are particularly good places from which to collect pollen. The patient brings in pollen swiped from several different places. We then test those samples on the patient. The ones he/she tests positive to are used in the therapy (cotton swab is placed in the input beaker of the device, program 998).

We have had excellent success with this method. Unfortunately, this application can only take place during the pollen season. It has proven effective to store the samples sorted by area and, if needed (after testing the patient), to use them during the winter months for therapy.

Every patient is instructed to return for renewed testing and therapy if he/she experiences a recurrence of hay fever after the conclusion of pollinosis therapy. The patient must be aware of the fact that **each pollen season, practically each summer's day, might bring on new, previously non-existent allergies.**

The fact that a hay fever patient once had a pollen allergy proves that he/she is susceptible to allergies. Even after successful therapy of one or several pollen allergies, new allergies to different kinds of pollen may appear and again trigger the symptomatology of pollinosis.

9 Inhalation Allergies

Inhalation allergies (also called airborne allergies) are allergic reactions caused by allergens in the air coming into contact with the mucous membrane of nose, eyes, and respiratory tracts. There are a great number of possible allergens; the symptomatology is relatively uniform:

- Allergic conjunctivitis.
- Allergic cold and cough.
- Spastic bronchitis.
- Exogenous allergic bronchial asthma.

Due to its specific characteristics, the most common and significant form—hay fever—is addressed separately in its own chapter.

In the following discussion, we are not attempting to completely cover, in detail, all other inhalation allergies. Instead, we would like to pass on the knowledge and experience we have gained from our own practice. Although definitely interesting, it does not always concur with current scientific points of view.

Symptomatology

Inhalation allergies commonly begin with a gradual, barely noticeable irritation of the mucous membrane. Children often develop a particular tic such as rubbing the eyes, twitching, pulling, scraping, or pressing the nose or grimacing in a variety of forms.

Figures 9.1 to 9.4 illustrate typical examples. The individual patient always makes the same type of movements, which are considered a tic or sometimes also called a "non-sensical habit." Rarely does anyone make the connection to an allergy.

Adults display similar, yet less obvious symptoms. Compulsive pulling or rubbing on the nose, often only on one side, as well as restrained coughing frequently indicates the mechanisms of inhalation allergies.

In contrast to the seasonal allergies that occur during the time when certain plants are flowering, a typical manifestation of other inhalation allergies is an acute reaction to an allergen someone is occasionally exposed to or "persistent" mucous membrane symptoms. The latter is caused by frequent to constant exposure to an allergen.

Figs. 9.1 to 9.4 Mild inhalation allergy concurrent with chronic allergen impact (e. g., in the home) cause chronic mucous membrane irritation that often leads to stereotypical, habitual involuntary muscle contraction. In the case of children, these are often considered a tic or a "non-sensical habit." In fact, they should be considered symptoms that hint at a possible allergy.

Diagnosis

Patients generally know the acute manifestations. They have noticed that occasional contact with certain animals (cats, dogs, horses, specific types of birds, etc.) or being in particular situations, areas, or rooms regularly triggers their allergy symptoms.

Being proficient at one or several relevant test methodologies makes the diagnosis of this allergy fairly easy. However, there are difficult cases that require discerning investigation, like a detective following leads, as the following example from our practice illustrates:

Patient W. S., born in 1984

The child grew up in an inn in the country adjacent to a farm. At the age of three, he experienced temporary asthmatic symptoms for the first time. It seemed that his symptoms were linked to occasional visits to the farm's stable. The following summer, the first incident of severe hay fever occurred. In the winter of 1989/90, pollinosis therapy was administered using a combination of six grasses. The patient's symptoms diminished considerably the following summer while the grasses were blooming. However, a recurrence of strong symptoms was experienced in late summer. A control test resulted in an allergy to stinging-nettle pollen. In the fall and winter of 1990/91, we treated, sequentially, for allergies to guinea pigs, rabbits, and finally stinging-nettle pollen.

After a short period without symptoms, the patient experienced an increasingly identifiable spastic cough. This was traced back to a sheep's wool allergy, which we also treated with inverse oscillation. After that, the boy was in good health, free from asthma or pollinosis symptoms. He no longer reacted to contact with the farm animals. Occasionally he experienced heavy conjunctivitis accompanied by episodic gel-type swelling. Often, the conjunctivitis was solely one puffy conjunctiva (Fig. 9.5).

By questioning the patient intensively, we found out that the acute conjunctivitis only occurred in specific situations:

- In very specific places in the stable (not, as before, in the case of contact with the animals but where old hay from previous years was stored).
- In very specific places in the cellar where vegetables were stored.
- When the boy came into close contact with his uncle's loden jacket, which he had worn for many years while working in the stable.

These observations finally led us to suspect mold fungi as the source of the allergic reaction. It had to be mold fungi that was thriving in the living conditions in the moist cool atmosphere of the cellar as well as in the old hay

Fig. 9.5 Acute conjunctivitis as a consequence of an allergy to Cladosporium herbarum, a fungus that was present on a farm in just a few places (e. g., old hay, root cellar, clothing worn in the barn).

of a stable. Indeed, after testing for all mold allergens we had at our disposal, we diagnosed an allergy to **Cladosporium herbarum**. We were able to prove the existence of this mold fungus in relevant places on the farm and in the clothing worn by the farmer in the barn.

Allergies to Mold Fungi

The case mentioned above of an acute, episodically occurring allergy to a specific type of mold fungi is an exceptional one.

Allergies to fungi are much more common in seasonal or chronic allergic manifestations as the spores of the fungus, and not the fungus itself, are the actual allergen carriers (as is also the case for wind-pollinated plants).

The spores of so-called **extramura**l wild mold fungi are emitted when the weather conditions are favorable (warmth, fog, moist air, etc.) and are dispersed by air currents. The deposits of spores are restricted to the seasons of spring, summer, and fall. During this period, the majority of spore pro-

ducers live as parasites or saprobes on higher-level plants. Walking or running on moist forest soil or leaves can stir up great clouds of spores that may cause severe symptoms in someone who is allergic. Therapists should always consider an allergy to mold fungi when given anamnestic clues to that effect. Quite often, an allergy to the spores of one or several fungi will hide behind a therapy-resistant pollinosis.

Allergies to **intramural** fungi (e. g., occurring inside a room or apartment) commonly cause persistent symptoms. Local fungi vegetation (e. g., on moist walls) will release spores throughout the year. A certain fluctuation is typical depending on the various climatic conditions of the room and different agitations of the spores.

Diagnosis

The test sets we formulated contain the most important antigens to fungi, partly individual allergens and partly combinations of allergens.

Up to 1997, the vials for mold fungi were found in several test sets. Eventually, the addition of necessary supplements created a somewhat confusing array. Thus we decided in 1998 to add all mold fungi antigens in alphabetical order to the "inhalation allergens" test set, regardless of whether the relevant type of fungi affected primarily inhalation or digestive tracts (as an ingestion allergen).

For detailed information, consult the book *Test Sets According to Dr. P. Schumacher* (Die Testsätze nach Dr. P. Schumacher).

If an allergy is suspected and testing results in the diagnosis of an allergy to one or more types of mold fungi, the patient has to be questioned in detail about where the relevant fungi spores in his/her particular case might come from. The following has proven effective for our practice:

We give the patients a packet of cotton swabs to take home. They are instructed to take swab samples from all suspected fungi sites, for example moist walls, any place where there is condensation or where water in any form is used (to quote the well-known mold fungi expert Krempl-Lamprecht, "no water, no fungi").

The vegetable drawer in the refrigerator, the bread container, as well as the garbage can and various storage pantries should be inspected carefully.

Air conditioning is always suspect. We know of several asthma patients who had severe asthma due to air-conditioned rooms during luxury vacations in tropical regions, on cruises, or during long flights.

Another common, yet rarely recognized, source of fungi is air humidifiers, specifically so-called **cool mist humidifiers**. We have come across this scenario several times: In the case of a 5-year-old boy, the mother spontaneously related that the child's breathing became significantly more labored

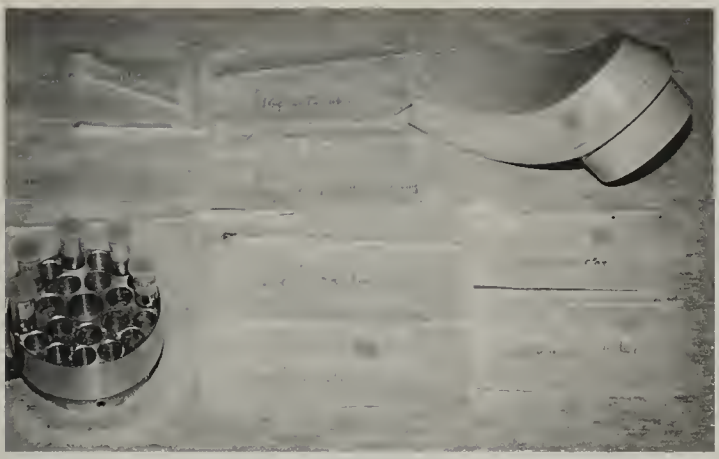

Fig. 9.6 Test situation in the case of an allergy to intramural mold fungi. The patient took swab samples from all suspected fungi sites in his home. Subsequent testing determines which cotton swabs contain the fungi that act as an allergen for the patient.

when the air humidifier was located next to his bed. She would have never supposed, however, that it might be the source of the problem. Swab samples from the storage tank and the exhaust spout proved the connection. They contained the mold fungi to which the child had developed an allergy. Figure 9.6 illustrates the evidence collected by a person allergic to mold fungi. As instructed, the cotton swabs were wiped firmly on the suspected sites in the home, placed in paper bags, labeled, and brought to us. Additionally, the family brought along the air humidifier's spout (upper right in the photo).

Allergy testing—cotton swab to patient—determined which samples contained allergens for this particular patient. In this case, we established positive tests to the inside of the toilet, the drainpipe of the toilet, and the humidifier. The relevant samples are marked with a red dot.

Anyone who knows how to do the identification test can use the sample vials (lower left in photo) to identify the type of fungi.

Therapy

Treating mold fungi with physical methodologies has been difficult to date as true avoidance of the allergen is rarely possible in the case of intramural fungi. Of course, whenever possible, the fungi will be deprived of their living conditions, that is to say, moisture. However, it is almost impossible to ensure that a home affected by mold may be completely decontaminated.

For this reason we have often had to accept that relapses would occur when treating with inverse oscillation coupled with the avoidance of the allergen.

The new therapy methodologies, without avoidance of the allergen, have changed the situation. If what we have experienced so far is anything to go by, these methodologies offer a simpler way to eliminate the patient's allergy.

Allergies to Synthetic Substances

Having become proficient in the application of physical testing methodologies, we have been able to uncover a variety of allergological correlations, previously unknown or underrated.

Polyester Allergy (Toy Asthma)

A typical example are specific polyester fiber allergies. These 100% synthetic fibers were developed to manufacture cuddly toys or doll's hair that is particularly shiny, easy to comb and wash (e. g., Barbie dolls, My Little Pony). They have proven to be aggressively allergenic, similar to pollen of grasses or cat epithelia. These toys are very popular with children (the Barbie doll, for example, is a billion dollar business worldwide). Children cuddle the dolls or animals, comb their hair, and sleep with them, but seldom are they recognized or even suspected as the cause of allergic symptoms. (Fig. 9.7 illustrates the wonderful fiber quality of the mane of one of the millions of My Little Ponies sold. Fig. 9.8 shows one of the popular Barbies. Fig. 9.9 shows a Poppel, a cuddly toy that was very popular with American children, but also extremely allergenic. Fig. 9.10 shows the European counterpart with the same fiber quality.)

Usually, an allergy to these fibers develops gradually. It will often begin with habitual tics (see Figs. 9.1–9.4). For the most part, a chronic therapy-resistant cold or cough follows, resulting in full-blown bronchial asthma. Clearly gaining in importance, we have coined the term toy asthma for this remarkably characteristic symptomatology.

From the point of view of the toy manufacturing industry, the quality of the fibers is quite versatile. They can easily be dyed, washed, and combed. They do not get tangled and do not burn, etc. To date, their role as an extremely potent allergen has been unknown.

As is typical with great commercial success, it did not take long for imitations to appear on the market. Interestingly, these cheaper, mostly European products, hardly ever acted as allergens. The lower fiber quality is easily

Figs. 9.7 to 9.10 Toy polyester: Among the most popular toys worldwide are Barbie dolls and My Little Ponies. The fibers used for the hair and/or mane are just as allergenic as cat hair. The soft synthetic fur of many plush toys is often manufactured in Asia. The lower left photo shows a "Poppel," once a favorite of children in the United States. Its fur is also strongly allergenic. Increasingly, the same fibers are used in Europe in the manufacture of dolls or cuddly animals (photo lower right).

recognized as the hair is a lot less shiny, tends to be shaggy, and gets tangled easily.

In recent years, some of the large traditional soft toy manufacturers seem to have followed the example set by the United States and have begun replacing the plush textiles traditionally used with synthetic polyester fur. Consequently, allergies to toys of European origin have been increasing.

It is surprising that so far allergies to other polyester fibers, designed for clothes and domestic textiles, etc. have rarely been observed. It appears that the very specific processing of the fibers makes them ideal for use in toy manufacturing, whilst at the same time creating a potent allergen.

Diagnosis

Diagnosing a toy polyester allergy is simple as long as the correlations are taken into consideration and the tester is proficient in a relevant testing method. Before commencing with any testing, we recommend collecting a variety of suspected polyester fibers. Over several months, we took a sample of each and every fiber that turned out to be an allergen for a patient, stored them in glass vials, and added them to our extensive test set for inhalation allergens. The most recent test set "inhalation allergens" (from 1998 onward) contains several test vials with the most important toy polyester types.

If the patient tests positive to one or several of the collected substances, we diagnose a general polyester allergy. At that point, it is not clear which of the numerous toys the child owns are the actual source of the allergy.

To find out we ask the patients to bring any furry animals, dolls, etc. they have at home when they next visit our practice. We test the often extensive selection, choosing the toys that are both allowed and forbidden. The IR transmitter-receiver (ISE) (see p. 69) has proven very valuable for these and similar kinds of testing situations. It is sufficient to place the mobile sender on the surface to be tested: The brass plate at the bottom registers the information and then transmits it wirelessly to the receiver. Connected to the test device via cables, the receiver registers the patient's reaction to the substance being tested.

This makes quick testing of the many objects possible while not placing undue stress upon the child. No matter which method is used, the subsequent progression makes the test results self-evident. If the diagnosis is correct and the identified allergen is removed from the child's environment, allergy symptoms will disappear within few days. In other words, the correct diagnosis and subsequent elimination of the toys in question is already a valid therapy in itself.

A sudden improvement of symptoms, which have been experienced for many months or years, is quite impressive, particularly in the case of children suffering from polyester allergy.

Here is another example of toy asthma from the practice:

Patient N. A., born in 1982

The child was healthy until she turned 6 years of age. Upon starting school, a chronic therapy-resistant cough appeared. She suffered increasingly from attacks of spastic bronchitis to severe asthma attacks. She had to be hospitalized several times for asthma and pneumonia. Several allergy tests conducted at that time did not show any positive results. Interestingly, the child's condition initially deteriorated each time she was hospitalized until intensive chemotherapy started to take effect. During the periods between heavy asthma attacks, the child was continuously administered anti-allergic agents (sodium cromoglycate), bronchodilators, and more and more frequently corticoids.

It was at this point that we met the child. She had amassed plenty of experience with physicians and was quite anxious. She clutched her favorite doll, holding her closely (Fig. 9.11).

Fig. 9.11 Toy asthma. The child suffered from severe bronchial asthma caused by the hair of her favorite doll. A constant companion during all hospital visits, the more the child cuddled the doll the worse she felt. A polyester allergy diagnosis and the subsequent elimination of the doll brought about an immediate and long-term cure.

We quickly diagnosed a polyester allergy. It turned out that the doll's wonderfully soft hair was the source of the allergy. The worse the child felt, the more urgently she desired the doll and the closer she held it. The doll was the steady companion, meant to comfort the child, during all hospital visits.

The doll was replaced with a non-allergenic doll that was just as pretty. Within a few days the child became more animated, stopped coughing, and has since been free from any bronchospastic attacks!

Other Allergies to Synthetic Substances

Many other symptomologies that we have little or no experience with belong in the section Allergies to Synthetic Substances. For example, in our pediatric practice **allergies to various domestic toxins** play a lesser role. We are under the impression that longer exposure is needed to develop a true allergy in this case. Besides, the lines of distinction between toxic effects and a true sensitization are not clearly defined. Domestic toxins (e. g., formaldehyde, wood preservatives, paint thinner, sealing lacquers) may certainly be toxic to an organism; however, they are seldom allergenic.

Several times in recent years we have observed a rather strange phenomenon, an **allergy to anti-allergenic bedding materials**.

Based upon the general increase and popularization of allergies over the course of the last decades, industry discovered new market potential. Products labeled non-allergenic, specifically suitable for allergy sufferers, appear more frequently.

In the course of decontaminating their home numerous patients classified as being allergic to house dust mites (to be discussed later) require specific, non-allergenic bedding materials. This is considered a necessary step to recovery. Physicians commonly recommend so-called non-allergenic beds, which are available in scores. Yet, as experience has proven, these beds may very well act as allergens themselves. The material in question is often synthetic foam used in larger blocks or as flakes, depending on the purpose. After several pertinent observations in recent years, we have added several such anti-allergenic substances to our testing materials. Again and again patients turn out to have a proven allergy to these materials.

Allergies to Animal Epithelia

Allergies to the most varied animal types have risen considerably in recent years. Besides an increased tendency to develop allergies more easily (environmental stressors, etc.), many more pets are kept in homes in urban areas. This seems to also play a significant role. Cats and various rodents are particularly important in this case as their epithelia shows strong allergenic potential. Rudolph and his coworkers found that 54.6% of people exposed to cats (Siamese cats 64%) and about 60% exposed to guinea pigs develop sensitivities.

The rate of sensitization is lower in the case of dogs (depending on the breed 20 to 30%, with schnauzers and boxers at the top of this range). Different sensitization rates for dogs of various breeds indicate that breed-related peculiarities should be taken into consideration during treatment.

We have observed that in many cases treatment with a type-specific basic antigen, (e. g., cat epithelia, dog epithelia, guinea pigs) can effect an allergen tolerance to many animals of a particular breed. Yet, certain breeds will not be addressed and will have to be treated separately.

Here is an **example** to illustrate the situation:

Patient N. S., born in 1983
For several months the child was plagued by asthma attacks during or after visiting his grandmother. The cat was suspected, and testing diagnosed an allergy to cat epithelia.

The child was not allowed to visit his grandmother for several weeks while allergy therapy, using inverted oscillation of the cat allergen, was taking place. Subsequently, he no longer reacted to his grandmother's cat. Feeling safe with cats now, the child came into contact with a pedigreed Persian cat a short while later. Immediately he had another cat asthma attack.

Here is an almost identical example illustrating allergy to dog epithelia. We treated with the basic antigen for dogs. Subsequently, no further reaction occurred when in contact with the aunt's German Shepherd dog that had caused asthma prior to treatment. However, a distinct allergic reaction occurred when the child came into contact with a Golden Retriever in the neighborhood.

Because of these and similar observations when treating allergies to specific animals (guinea pigs, golden hamsters etc. included), we started to routinely include the epithelia of specific animals relevant to a patient, i. e. in the family or surroundings.

We ask the patient to bring some hair of the animal in question to our practice. It is important that the hair is **combed**, not cut, as it needs to contain the actual antigen, the skin cells (epithelia) of the animal.

We keep this material in a glass vial or paper bag and use it for every therapy session, combined with the basic antigen (cat, dog, guinea pig, etc.).

The **therapy methodology** used, be it the inverted oscillation of an allergen or meridian-based therapy is not that important. In any case, the patient should then be able to tolerate contact with the animal without experiencing any reaction whatsoever.

A possible residual Type IV element, pure skin reactions in case of intensive contact with the animal, was discussed on page 62 (see Fig. 5.9).

To date allopathic allergology has had no real therapeutic possibilities in the cases of animal allergies, causing primarily physicians, secondarily patients, to develop a kind of **hysterical fear of animals**. Every allergological textbook strictly for**bids pets** for any patients suffering from hay fever, neurodermatitis, and asthma as well as for any person with a potential to develop allergies.

Patients are instructed accordingly, which often results in distressing family scenes when the beloved family member (cat, dog, guinea pig, etc.) must be banned or even euthanized.

In 1996, my book *Tierallergien sind heilbar* (Allergies to animals can be healed) was published, which deals with this subject in detail.

Allergy to Horses

Specific criteria have to be taken into consideration in the case of allergy to horses. It does not exclusively manifest in people who are in direct contact with horses (riders, farmers, horse breeders, etc.).

More important and more common is the sensitization via **horsehair** contained in mattresses and old upholstery. The tautness and elasticity of mane and tail hair make them particularly suitable as mattress fillers. They have been partially replaced by more modern synthetic material but have, of late, regained popularity with the organic movement. Therefore, we often encounter people allergic to horsehair even though they have never had direct contact with a horse.

Allergy to Sheep's Wool

Sheep's wool allergy has a special place among the inhalation allergies to animal epithelia.

Experience shows that it occurs more often than actually diagnosed. Often the sheep's wool antigen is not found in allergologists' test sets or is not

routinely tested for. On the other hand, it is by far less aggressively allergenic than many other animal antigens.

It is nosologically significant in alpine countries where traditionally **unprocessed sheep's wool** is used for clothing, textiles, carpets, etc.

Industrially processed sheep's wool (e. g., knitting wool or wool textiles), hardly ever acts as an allergen.

Industrial coloring, waterproofing, or any other type of processing usually diminishes the allergen potential of weak allergens or causes it to disappear completely. The same applies to processing of sheep's wool by furriers. Its allergen potential depends on the type and degree of processing. Most sheep's wool undergoes numerous chemical and mechanical processes before it is made into coats, jackets, or other clothing. Consequently, its natural characteristics, including its antigenicity, barely remain.

This is not the case for sheep's wool that has been intentionally left in its natural state. Over the course of the last decade, the trend toward using more unprocessed natural materials in all areas of life also repopularized **natural sheep's wool** (in the form of rugs, bed fill, car seat covers, buntings) as well as **homespun wool**, unprocessed milled wool, and felt in a variety of uses.

Sometimes a pediatrician has to employ the skills of a detective when dealing with sheep's wool allergy, as demonstrated in the following **example**:

Patient F. M., born in 1984

The child came to see us at age 4 years due to bronchial asthma he had experienced for 2 years. Anamnesis illustrated that he had had neurodermatitis in the first 2 years, which gradually disappeared with the onset of asthma. At our initial examination, his skin was almost clear except for some residual places in the bends of the arms and knees. They worsened when the child was particularly stressed or ill, etc. The asthma was consistently present and manifested as a moderate bronchospasm, which worsened at night.

As expected, allergy testing resulted in a "central" stressor caused by a chronic allergy to cow's milk protein. After treating it with all the medical skills at our disposal, the neurodermatitis disappeared. After milk therapy the asthma symptoms improved significantly; however, a therapy-resistant nightly cough with occasional dyspnea remained.

Testing with inhalation allergens showed an allergy to sheep's wool. The subsequent search for sheep's wool in the child's environment, particularly the bed, at first yielded no results. The child had already been sleeping in "anti-allergenic beds" for 2 years. As advised by physicians (suspected house dust mite allergy), the family had eliminated carpets and wool materials a long time ago.

Fig. 9.**12** Sheep's wool allergy. The boy's nighttime cuddly toy, filled with unwashed sheep's wool, turned out to be the cause of a chronic asthma symptomatology, worsening at night.

A chance remark the mother made led us to the source of the problem. She said that the boy would not sleep unless he had his nighttime cuddly toy close by. The child brought it to our practice for the following appointment. It was a doll-like object, made from a diaper, partially stuffed and tied off to make a soft "head" (Fig. 9.**12**).

The filling turned out to be pure, unwashed sheep's wool. (Tyrolean farmers have always believed that the freshly sheared, unwashed wool of mountain sheep protects against illnesses.) The boy's grandmother had given him the toy in infancy. The parents had long since forgotten what type of filling it contained. The boy's adamant protestations made it impossible to eliminate the toy, though he did tolerate the filling being exchanged for a different material. From then on the boy slept through the night, free from coughing and bronchospasms.

Allergy to Goose Down

When we began our statistical analysis in terms of allergen distribution, we realized that goose down allergy was frequently underestimated.

Goose down ranked third in the list of allergens after wheat and cow's milk, which are consumed daily. Among the inhalation allergies, it ranked first, way ahead of any others, whereas, for example, the house dust mite antigen definitely played a minor role.

The next chapter discusses the house dust mite allergy in detail. We would like to point out here that a large percentage of people diagnosed with and unsuccessfully treated for mite allergy seem to be, in actual fact, allergic to down. Among the 29 people allergic to down that we treated successfully, 16 (more than half) had previously been incorrectly diagnosed with and subsequently treated for house dust mite allergy.

The reason that **goose down has been greatly underestimated as an allergen**, to date, seems to be based in the habitual methodology of prick testing. Industry offers goose down antigen and it is available everywhere. For whatever reason though, it is not included in most allergological test sets. Consequently, no testing is done.

The following table is extracted from a modern standard work of pediatric allergology (Wahn et al. 1987) and lists the recommendations for prick testing children.

Test spectrum—Recommendations for prick testing (R. Jarisch 1987)

Concise test	Advanced test	Extensive test
House dust mite	House dust mite	House dust mite
Cat epithelia	Cat epithelia	Cat epithelia
Birch pollen	Birch pollen	Birch pollen
Grasses pollen	Grasses pollen	Grasses pollen
	Rye pollen	Rye pollen
	Ribwort pollen	Ribwort pollen
	Common mugwort pollen	Common mugwort pollen
	Alternaria	*Alternaria*
	Guinea pigs	Guinea pigs
	Dog epithelia	Dog epithelia

cont.

Table p. 145 cont.
Test spectrum—Recommendations for prick testing (R. Jarisch 1987)

Concise test	Advanced test	Extensive test
	Horse epithelia	Horse epithelia
	Flour mite	Flour mite
		Hazel pollen
		Alder pollen
		Beech pollen
		Oak pollen
		Willow pollen
		Poplar pollen
		Nettle pollen
		Ragweed pollen
		Aspergillus
		Mucor
		Penicillium
		Candida
		Rabbit epithelia
		Hamster epithelia

For inexplicable reasons an allergen as important and common as **goose down** is rarely contained in otherwise extensive allergen collections. Thus it is seldom used for testing, and subsequently its symptomatology is often misdiagnosed.

Many of us sleep in feather beds or use feather pillows. These pillows or blankets are almost exclusively filled with goose down containing a percentage of de-quilled feathers depending on quality.

The fact that down is extremely light and tends not to clump makes it very popular. The lighter and fluffier a down, the more expensive it is and the higher its allergen potential.

The microscopically fine dust that is created when using the beds is particularly allergenic. It passes through the thickest linen, stressing the patient for many hours every night.

Symptomatology

It is surprising and incomprehensible how rarely physicians and patients consider an **allergy to bedding materials** even though there are often enough hints that point to it.

First and foremost is the fact that the **symptoms** (often cough or dyspnea) primarily or exclusively **occur during the night.** In less severe cases frequent hemming, itchy eyes or nose, and sneezing attracts attention.

In the case of children, the first hour in bed is the worst, since it takes a while for them to settle down. The symptoms improve considerably during the first quiet sleep phase and worsen again in the early morning hours.

Strongly fluctuating symptoms and occasionally longer periods of abatement, even though the external situation remains unchanged, do not contradict the allergic mechanism. As with all allergies, the patient's general condition—the presence or lack of additional stressors—also influences the symptoms significantly. Incidentally, goose down is not limited to down beds. Sleeping bags for mountaineers and campers as well as warm winter coats and jackets, etc. are often filled with down.

Situations similar to the two illustrated previously can also occur in children in the case of a down allergy. The allergen is always close to the child in the form of a comforting object and/or security blanket and clutched even more when the child is sick.

A further **example**:

Patient B. T., born in 1985

With a family history of allergies, and thus genetically predisposed, the boy first came to our practice at the age of three. For months he had been suffering from an increasing tendency to spastic bronchitis interspersed with chronic irritable cough. Allopathic prick and RAST testing continuously produced negative results. The patient was frequently administered antibiotics, mast cell stabilizers, and bronchial vasodilators. We were able to quickly diagnose this case as an allergy to goose down. The boy had brought along his security blanket in the form of a down pillow (Fig. 9.**13**). It went with him everywhere as his comfort object, on visits to doctors, hospital visits, and in bouts of illness, etc.

After treating the down allergy, the symptoms disappeared. About a year later, the boy developed a polyester allergy, which was easily remedied by eliminating a few of his toy animals.

Since then the patient has had no more complaints. The parents and child know that new sensitivities may occur at any time. They also know that almost every allergy can be easily treated. The family no longer considers his atopic constitution life threatening.

Fig. 9.13 Allergy to goose down. The anxious, insecure child carries his allergen with him everywhere, a pillow filled with down acting as his security blanket. The more difficult his breathing, the more he feels in need of comfort, thus the harder he clutches his pillow.

Allergies to Other Bird Feathers

Besides the goose down allergy, whose significance is obvious since down is used in a myriad of bedding materials, there are, of course, **allergies to other birds**. According to our information, **budgerigars** and **canaries** are equally allergenic. Next in line are **parrots**, **chickens** and finally, pet birds kept in the home such as the **zebra finch** or **gold finch**.

After acquiring feathers of all types of birds which were found to cause allergies, labeling them, and placing them in glass vials, we set up a separate allergen collection for bird feathers.

The Problem with House Dust Mites

Next to grass pollens, house dust mites rank the highest by far in practically every allergological statistic on inhalation allergens. However, in our experience a surprisingly small percentage appear as relevant house dust mite allergies.

This discrepancy is striking. It may be explained by the fundamentally differing test methodologies. **Immunological test methodologies** are based on positive antibodies. As has been proven, these are not necessarily synonymous with an allergy the patient actually suffers from (see also p. 92).

Testing on the informational level presents a very different picture:

Physical testing enables a proficient tester to differentiate between asymptomatic antibody carriers and a true allergen-specific allergy reaction.

This distinction has proven particularly important in the case of the house dust mite's antigen. One important reason why mite-specific antibodies appear so frequently in the population seems to be that **the house dust mite is frequently the first animal protein with which a human being comes into contact after birth.**

House dust mites, of course, live in every bed of an infant nursery in hospitals, just like in all other bedrooms worldwide. The mite excrement contains a protein that is considered to be the actual antigen (Tovey et al. 1981). Even considering this in detail, we cannot think of any other single potent allergen that would play such an important role that early in every person's life.

A newborn's immune system seems to react relatively quickly to foreign protein. The antibodies created by the immune system by no means have to trigger allergic symptoms. We saw this in the previously mentioned study by Hattewig and coworkers who determined that almost one-third of all healthy infants (with no allergy symptoms of any kind) tested positive to antibodies of chicken egg protein after it had been added to their diet (Hattewig et al. 1984). Even the minutest amounts of chicken egg protein the infant ingests via breast feeding may lead to the creation of antibodies without the child developing any symptoms (Gerrard 1979). We do not know of any studies with healthy infants investigating the occurrence of specific IgE antibodies to the house dust mite antigen. Doubtlessly they would be interesting.

Let us remember: Relevant allergies to the antigen of the house dust mite (*Dermatophagoides pteronyssinus*) and the flour mite (*Dermatophagoides farinae*) are certainly more uncommon than the results of immunological test methodologies indicate.

Neither a positive skin test nor antibodies in the blood prove that a suspected allergy symptomatology is indeed caused by a house dust mite allergy.

The only definite proof would be if **the symptoms disappeared after successful therapy**. So far, allopathic allergology has not been able to do this, whereas a successful physical allergy therapy can achieve this without difficulty.

The fact that immunological mite tests frequently turn out positive has allergologists worldwide placing particular importance on the house dust mite allergy. Subsequently, **the actual allergens affecting a patient are often overlooked.**

We know of dozens of cases where dramatic measures against the house dust mite were initiated. People spent large amounts of money to convert cozy homes into bleak, sterile rooms. Patients had to undergo hyposensitization and climate treatments, etc. for months, even years. None of these efforts were successful as the actual cause was, for example, the favorite doll that accompanied the patient everywhere, or the teddy bear without which sleep was impossible.

A **typical example** of a misdiagnosis of a house dust mite allergy:

Patient K. U., born in 1976

Since the the age of five increasing bronchial asthma, worsening at night. From the onset, extensive administration of corticodes and bronchial pharmaceuticals [!]. Additionally, frequent antibiotics. After several years of unsuccessful therapy the child's mother steadfastly refused any further chemotherapy. An attempt by one of the physicians to employ long-term psychotherapy failed. So did several attempts using alternative medicine.

Clinical allergy testing (prick and RAST test) several years ago diagnosed *"Mites: extremely positive! Grasses, herbs, trees, mold, cats, horses, cows, dogs: negative."*

This diagnosis could not be more typical (that is why we repeat it verbatum). A positive test to mites is considered a sufficient diagnosis, particularly since all other test results are negative.

Despite the fact that the symptoms worsened during the night, the goose down antigen was not considered and therefore not tested for.

Based on the test results, the family took the usual measures to eliminate the house dust mite. Jaded by previous medical advice, they went about it half-heartedly and kept their down blankets. We saw the patient for the first time at age 11, at which point he had suffered with asthma for almost 6 years. In the previous weeks dyspnea was particularly severe; lid swelling was also observed. Labored, hissing breathing was one indication that the lung capacity was severely impaired.

The respiratory volume was considerably reduced, the radiograph showed severe pulmonary emphysema concurrent with expanded intercostal space, phrenoptosis, heart atrophy (usually more spherical), as well as increased perihilar bronchial markings (Fig. 9.**14**). The ECG indicated dis-

Fig. 9.**14** Radiological diagnosis in the case of down asthma. Severe, chronic bronchial asthma. Misdiagnosed as allergic to house dust mite antigen 6 years ago. Subsequent incorrect treatment. Distinct pulmonary emphysema, phrenoptosis, distinct perihilar markings, atrophied image of the heart.

tinct signs of a chronic cor pulmonale with emphasized P-wave and an increased load on the right side of the heart.

The patient's overall condition illustrated severe bronchial asthma, turned chronic, showing all signs of beginning long-term damage of the bronchials and heart.

Allergy testing resulted in the diagnosis most important for the patient: We definitely did not find an allergy to house dust mites. However, we did find a very strong **allergy to goose down**.

We informed the parents of the diagnosis, discussing all necessary steps. Before the family returned home, we conducted a combined treatment con-

sisting of inhalation and bioresonance therapy to increase lung capacity. We also carried out laser acupuncture to treat simultaneous chronic maxillary sinusitis. (Simultaneous sinusitis in the case of chronic inhalation allergies occurs often and, because of enormous allergen depositories in the paranasal sinuses, must not be overlooked. We will discuss this important point later in detail.)

That evening, the patient suffered his most severe asthma attack. It was also the last in his life. Fortunately, we had already predicted a possible reaction to the allergen mobilization in the paranasal sinuses. The family was prepared for it. They coped relatively calmly with the severe dyspnea the child experienced. The same day they eliminated all down from the home; the boy's symptoms almost immediately disappeared. The patient continued to see us for a while longer. First we treated the sinusitis and finally eliminated the down allergy. A few weeks ago we received a letter from the family informing us about the further development. We had not seen the patient in 3 years and had asked the parents how he had been doing in the course of those years. Here is an extract of the father's letter verbatim:

"Since the day our son had his last treatment in your practice, he has never had any signs of asthma. He has been healthy ever since! I am very surprised and wonder why still so few physicians employ this treatment methodology as certainly many patients would benefit from it!"

More and more patients vehemently express their opinions about the general ignorance of allopathic medicine to employ uncommon treatment methodologies. We believe that in the future the pressure patients exert will contribute considerably to the advancement and the breakthrough of successful treatment methodologies that are still novel in the realm of allopathic medicine.

The case history described is exemplary for many others and shows the fateful course of an allergy that was misdiagnosed from the outset. For the reasons explained above, particularly the classification "house dust mite allergy" is used far too frequently.

Besides the diagnostic aspect, this case also gives us the opportunity to elaborate on the significance of **concurrent sinusitis** in the case of inhalation allergies:

Many patients suffering from chronic inhalation allergies develop chronic maxillary sinusitis simultaneously to the allergy-specific symptoms (in this case bronchial asthma). It seems that allergen particles that adhere to the nasal mucosa through breathing are transferred to the maxillary sinuses. If ignored and not elimintated, they can create an allergen depository there that may cause persistent allergy symptoms even if the allergen has already been eliminated from the patient's environment. For this reason we always include paranasal sinuses in our diagnosis in the case of inhalation allergies.

Regulation thermography (Rost 1983) has proven particularly effective in this regard. It supplies information about a patient's general regulation processes and the current stress condition of the paranasal sinuses.

In the case of a positive diagnosis—as mentioned above almost obligatory for people suffering from inhalation allergies—we routinely initiate a therapy to relieve the chronic sinusitis as the first step in allergy treatment. We consciously avoid all chemical means that reduce the swelling in the mucous membrane. For several years, bioresonance therapy (program 101, followed by program 500 using the gold-finger electrode perinasally) combined with laser acupuncture has proven effective. The treatment loosens the mucous, occasionally creating severe reactions to the often heavy discharge. This does not come as a surprise; after all we are emptying an allergen depository.

10 Bronchial Asthma

Pathogenesis

Asthma is a multi-layered illness that tends to episodic or consistent spastic constriction of the bronchials coupled with inflammatory changes in the bronchial mucous membrane. It frequently begins during childhood. Initially, allergic mechanisms almost always play a central role.

Biochemical cellular–immunological mechanisms occurring on the material level have largely been elucidated. Relatively new and important is the knowledge of a delayed phase that occurs in addition to the allergic acute reaction (e. g., mast cell activation, histamine release). It seems to be pathophysiologically significant in the case of asthma.

A delayed reaction develops several hours after initial contact with the allergen. It may last for more than 12 hours. Besides mast cells, macrophages, T-lymphocytes, eosinophile and neutrophile granulocytes are involved. Via various mediators, a complex inflammatory process occurs which exceeds the pure allergic mucous membrane reaction and determines the clinical symptomatology of asthma (Fig. 10.1).

The realization of the importance of the role played by chronic inflammation in chronic bronchial asthma has recently pushed the interest re-

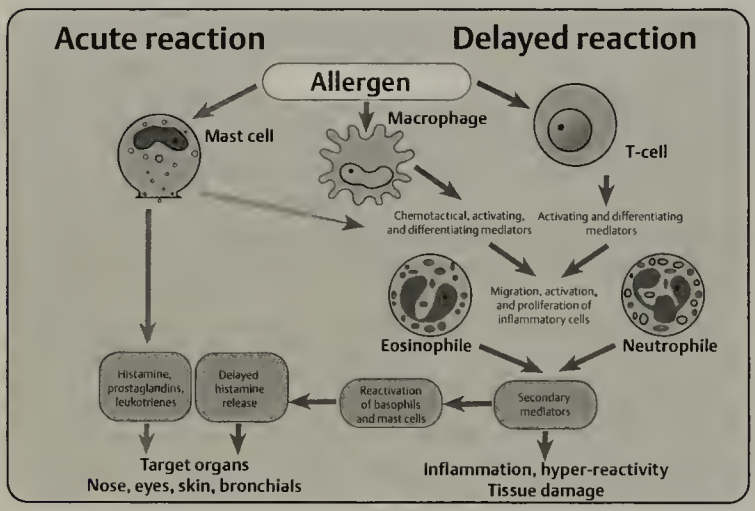

Fig. 10.1 Schematic diagram of the allergic delayed reaction. A delayed mechanism was found to occur besides the known acute reaction via mast cells and mediators.

garding allergic mechanisms into the background. In the euphoria accompanying the newly acquired knowledge, it is often overlooked that even the biochemical cellular processes of the delayed reaction that lead to inflammation are a response of the body's contact with an allergen. Therefore, characteristically, they need to be classified in the category of allergy.

A definition of bronchial asthma commonly accepted today is: "*Asthma is a variable and reversible obstruction of the respiratory tract as a consequence of inflammation and hyper-reaction of the respiratory tract*" (Nolte 1991).

This briefest definition possible describes the pathomechanism of asthma. However, it does not mention anything about its underlying causes and triggers.

We are convinced that at the onset of the disease each asthma patient had one, several, or multiple allergies. They were the foundation that preceded all further pathological processes.

To a certain extent the bronchials "**learn**" from the reaction to an allergen the processes leading to obstruction. They become increasingly hypersensitive. Eventually, highly varied influences may prompt similar reactions even though no allergen is present.

These influences are primarily infections (specifically **viral infections**) and **physical exertion**. Also included are **mental stress** and **mechanical or chemical irritation** such as dust, air pollutants, and chemical vapors.

Hyper-reactive bronchials are therefore the result of an original allergic event. However, as the allergy progresses, additional non-allergic influences increasingly cause spasms, edema, and increased mucous production, the triad characteristics for asthma. Eventually, the allergic element may completely move into the background.

The **acute allergic asthma reaction** is frequently the beginning of the predetermined progression. It is often part of the simple inhalation allergies, as discussed in the previous chapters, and is particularly well demonstrated in the example of hay fever. The choice of **organ** in which the allergy manifests depends primarily upon a person's predisposition: conjunctiva, mucous membrane of nose, or bronchials. Atopics display asthma symptoms, most frequently, in the first years; other patients may experience hay fever in each pollen season for decades and never develop any bronchial symptoms. Thus, not every inhalation allergy leads to asthma. Similarly, not every asthma allergy is automatically linked with a bronchial hyper-reactivity, as defined above.

As the last case history demonstrated (p. 151 Fig. 9.14:), the pure asthma allergy mechanism may take place over a long period without causing a hyper-reactivity of the bronchials. In the case of the boy who had been suffering for years from severe asthmatic symptoms, the correct allergen diagnosis and elimination of the allergy were sufficient to achieve immediate and long-term healing. The patients pictured in Figure 9.11 (polyester allergy), Figure 9.12: (sheep's wool allergy), and Figure 9.13: (goose down allergy) are also among this group.

After eliminating the allergy, the asthma symptoms disappeared for all these children. No recurrence was noted, not even when they were under stress as discussed above (infections, physical exertion, etc.). In these cases, a true bronchial hyper-reactivity, independent of the allergy, had not developed despite severe and long-term asthmatic symptomatology.

On the other hand, there are patients who experience the phase of pure allergic asthmatic symptomatology only briefly and mildly. Yet, shortly thereafter all signs of bronchial hyper-reaction will occur. These cases often portray the symptomatology of **relapsing spastic bronchitis**. That is to say, bronchospastic states more or less regularly complicate ordinary bronchopulmonary infections. A subtle search for the allergen in these patients, almost exclusively children, discovers one or more allergies that absolutely need to be treated. If this does not happen, the route of bronchial hyper-reactivity can no longer be avoided.

In these cases, the search for the allergen may not be limited to inhalation allergies. **Food** and, above all, **food additives** ought to be considered. We would like to remind you of the allergies to salicylic acid and its derivatives, and also of pseudo-allergic reactions caused by the accumulation of food containing salicylate. Similarly, azo dyes and preservatives may cause asthma (e. g., "sulfite asthma" caused by wines and fruit containing sulfites, etc.). In this context, we refer you to the book *Die Testsätze nach Dr. P. Schumacher* (Test Sets According to Dr. P. Schumacher).

In the case of bronchial asthma, **chronic** (= **central**) **food allergies** also play a particular and as yet unknown role.

Chronic allergies to wheat or cow's milk protein, as described in the first part of this book, are often the hidden original source of bronchial asthma. Scientific medicine has coined the term **intrinsic asthma** for asthma cases that cannot be traced back to an exogenous allergic cause. We use the term **central asthma** knowing (and capable of proving) that in these cases the chronic allergic stress caused by sensitization to a staple ingested daily is frequently the deciding factor for the creation and continuation of asthmatic symptomatology. According to our experience, specifically **wheat protein** seems to have a particular affinity with the bronchial system. (Of course, asthma as a result of a chronic wheat allergy must not be confused

with an inhalation allergy to flour dust, commonly known as baker's asthma.)

From the point of view of chronic food allergies, the frequently observed **interrelationship with neurodermatitis** becomes comprehensible. The change from skin disease to asthma during childhood is commonly known. Interestingly, it has never caused any deliberations regarding a common cause of both symptomatologies. Both are considered atopic diseases and the term atopy, basically meaningless, was considered a sufficient explanation.

Specifically in the case of **wheat asthma**, an experienced observer will see subtle signs in the patient's face that point to a wheat allergy, even if other manifestations on the skin are missing (see the chapter on neurodermatitis for details about wheat allergy). Slight changes on the eyelids are typical. They may appear as swelling and/or creases as well as subtle impurities on the lips and in the perioral region.

Central asthma, as an expression of a chronic food allergy, often has associated inhalation allergies. They may manifest at some point in life and hide the true interrelations even more. Here, too, a reliable and accurate diagnosis is crucial. The standard statement of allergologists that almost every person suffering from asthma has an allergy to house dust mites, animal epithelia, and grass pollen may correspond to the results of immunological tests, but is of little use to the individual patient.

Therapy

As we have already mentioned several times, only the success of an allergen-specific therapy proves that the diagnosis was correct. Of course, this also applies to every asthma patient. However, physicians and patients have a very difficult time recognizing asthma for what it is. If a manifest bronchial hyper-reactivity has imposed itself onto the allergic situation, successful treatment of the allergy does not simultaneously eliminate the asthma symptoms. Complete and long-term healing of chronic bronchial asthma, characterized by hyper-reactive bronchials, therefore presupposes treatment of the allergies as well as the subsequent inflammatory symptomatology in the bronchials. Treating only one of them would definitely be insufficient.

In recent years, medicine has become very interested in using chemotherapy in the treatment of bronchial asthma. To date, asthma is the only treatable disease that statistically demonstrates a consistently increasing death rate. This alarming observation as well as recent discoveries regard-

ing the role of the inflammatory reaction in the pathogenesis of asthma has caused the birth of new therapeutic strategies worldwide. In an international consensus, experts have agreed on the efficacy of the liberal application of inhalational corticoids. Already indicated for moderate to severe asthma (cough and dyspnea more than three times a week, nocturnal asthma more than twice a month), it is recommended for use as a primarily inhalational anti-inflammatory therapy for treatment that administers regular inhalation of beta-2 agonists, nedocromil sodium chromoglycate and inhalational corticoids. Additionally, oral steroids may be prescribed for severe forms of asthma. Non-compliance with these guidelines may be used in a court of law against a physician. It would certainly be wrong and shortsighted to contest and/or dispute these guidelines established by international experts. In the case of severe chronic asthma, a stubborn refusal to use chemical means must be considered a medical faux pas from any point of view. When it comes to asthma, we do believe, however, that the crucial steps must be taken early on: in the phase in which the allergy is still predominant. Eliminating the allergic mechanisms may completely change and stop the predetermined progression from bronchial hyper-reactivity to severe, irreversible bronchial obstruction. As long as true elimination of allergies was impossible (allopathic medicine still believes this), diagnosing allergies in the case of asthma was only important insofar as it meant that the relevant allergen had to be avoided. Again, as demonstrated, this requires an exact diagnosis, a requirement that was not always fulfilled.

Asthma is the typical **allergy disease** as defined in Part I. Mechanisms, at first exclusively caused by allergen contact, become increasingly independent, eventually making the correlation to the allergy impossible to determine. In a sense, true causal therapy is only possible when all allergic stressors are eliminated. As necessary and indicated, all chemical-based therapies including the possibilities summarized in the "consensus guidelines," may be in many cases primarily hiding and suppressing symptoms.

Besides allergy treatment, the most important therapy for virtually every asthma patient, and chemotherapy (where necessary), a broad spectrum of **adjuvant measures** are necessary and make sense. They aim at freeing the organism from additional toxic or infectious stressors and therapy blockages. They also shift the patient's entire physical condition into a more sensitive and oscillating state.

In this case, **bioresonance therapy** has also proven very effective (therapy using the patient's own oscillations). In an acute condition, its effects provide noticeable relief and antispasmodic easement. In the interim, between attacks, it releases toxins and harmonizes. Using the BICOM device

for a basic therapy, its selection dependant on the individual case (ideally pre-tested), we always add a second treatment. For that localized treatment, we like to use some acupuncture points:

On the back, treatment of the point bladder 13 (lung point) using the gold finger or point electrode has proven effective (see Fig. 1.7, p. 21). On the front of the chest, we like to use the magnetic depth probe in the middle, above the sternum, aligned with the nipples (point cv17: see Fig. 1.8:, p. 21).

To avoid possible misunderstandings, we would like to emphasize once more that in the case of asthma bioresonance therapy is applied in two ways. One the one hand, as pure **allergy therapy** to free the patient from all allergic stressors, thus creating the condition for the eventual healing of their asthma. On the other hand, as **therapy using the patient's own oscillations**, which aims at relief, detoxification, and pacification of over-reactions.

In the case of asthma, **traditional Chinese acupuncture** also has a utilitarian regulation therapy that is effective and has an established area of indication. It influences primarily the general hyper-sensitivity of the bronchials and subsequently the severity and frequency of the asthma attacks. Acupuncture is commonly carried out between attacks. With children we always use the completely painless **laser acupuncture.** A series of three to five treatments every 2 or 3 months is usually sufficient. If the process is favorable, single refresher treatments are effective, two to four times annually over the course of several years. We already pointed out the significance of **sinusitis** occurring **simultaneously** with inhalation allergies (p. 152). In this case, a combination of laser acupuncture and bioresonance therapy has proven to be excellent treatment.

A holistic treatment plan includes carefully selected **homeopathic remedies** coupled with **intestinal cleansing** and **symbiotic regulation.** Additionally, consultations with the patient regarding an appropriate **general way of life are necessary**.

Generally, asthma patients should lead a life that differs as little as possible from the life of a healthy person! They should not anxiously avoid physical stressors. However, their life has to be adjusted to what an individual can reasonably deal with. Unless the patient tends to push him/herself too hard or has difficulty breathing while exercising, athletic activities are acceptable.

Many patients benefit significantly from learning a relaxation **breathing technique**. This technique should be practiced only under the guidance of a trained therapist. We do not advise using self-help books or brochures.

Nutrition also plays an important role in the life of an asthmatic person. We are not referring here to an allergen-free diet obligatory for anyone al-

lergic to foods. We are talking about general nutrition, that is, following a wholesome diet which these days, unfortunately, requires a certain amount of attention. The essence of a wholesome diet should be foods in their natural state, as unprocessed as possible. All colored, preserved, concentrated, industrially altered foods should be avoided. The same goes for sugar and white-flour products.

We found a one-sided, general diet based on grains, as recommended by many proponents of the whole-food diet, to be ineffective, especially in the case of children.

A significantly important aspect when treating chronic asthma cases is the monitoring and support by the physician. In the physical realm, the **peak flow meter** has proven an effective means to consistently control the current bronchial condition. The patients are expected to monitor themselves daily, recording the data. Even children easily learn this method. The minimum age is approximately 3 years. Objectifying and being aware of the breath facilitates therapy and may considerably prevent administration of pharmaceuticals. Asthma creates breathing difficulties, which in turn makes people afraid! For this reason alone, the physician's **psychological support** is particularly important for asthma patients.

Once the fateful mechanism of bronchial hyper-reactivity has started, any psychological stress, anxiety, etc. may lead to acute bronchial spasms. It is crucial that the patient trusts the physician and that the physician is understanding.

11 Ingestion Allergies

We define ingestion allergies as allergic reactions to substances that enter the body via the digestive tract. This includes foods or food components but also chemical substances such as food additives, pharmaceuticals, etc.

Most frequently, allergic reactions manifest on the **skin** as extremely varied exanthema, isolated itching sensation, urticaria, eczema, purpura, Quincke's edema, etc.

The **digestive tract** is implicated in approximately 20% of the cases. Frequent symptoms are nausea, vomiting, stomach pain, diarrhea, etc.

Bronchopulmonary reactions ranging from dyspnea and cough to acute asthma attack are less frequent, but must be taken into consideration. Finally, the **circulatory system** may also react, (e. g., tachycardia, extrasystole).

Acute Food Allergies

Anyone genetically predisposed to allergies may potentially develop sensitivities to most foods. Here, too, considerable differences in the allergen potential of each individual substance exist.

In our primarily pediatric data, **strawberries**, **citrus fruit** (including cultivated types of **tangerines**), **peaches**, **kiwis**, and **nuts** play a relatively important role; **chicken** egg protein, on the other hand, is less important than one might think judging by reports in accordant technical literature. (In several instances, we have previously discussed the discrepancy between positive IgE and actual allergy symptomatology). As to being an allergen, **meat**, of any kind, is not an issue for us either. In our experience, even though in many cases hard to digest, the much discussed pork rarely acts as an allergen. **Fish protein** seems to have a more significant effect on adults. A high degree of sensitization, including anaphylactic reactions, may occur.

Diagnosing food allergies is exclusively based on testing. We rely completely on biophysical tests and do not take into consideration the results of possible immunological test methodologies. Here as well, the successful outcome of the therapy confirms the diagnosis.

Diagnostic difficulties are rare. The more precise the information provided by the patient, the more specifically we can test.

Figures 11.1 to 11.4 illustrate examples of simple acute food allergies every physician encounters almost daily. They are easy to diagnose and can be reliably eliminated within a few days.

Fig. 11.1 Allergy to strawberries.

Fig. 11.2 Allergy to onions.

Fig. 11.3 Allergy to kiwis.

Fig. 11.4 Allergy to almonds.

We treat these types of allergies almost exclusively by applying the physical methodology without avoidance of the allergen. The amplified inverted oscillation of the allergen (**program 998**) and the methodologies utilizing the frequency 52 kHz (**program 530** in the case of the meridian technique; **program 977** when using ball electrodes) have proven very effective in our practice.

Of course, patients with extreme sensitivity to a specific ingestion allergen must be treated with particular care. The cases are rare, but often quite dramatic.

The following example illustrates this:

Patient S. L., born in 1951
Extreme sensitivity to elderberry. When ingesting elderberry in whatever form (juice, jam, etc.), onset of the most severe anaphylactic reactions occurred within a few minutes. Later, a milder version of these reactions also occurred simply when the patient came into contact with any part of the elderberry tree. The scent of the flowers themselves, touching the leaves, wood, etc. immediately brought about severe allergic reactions.

In a case like this, avoidance of the allergen comes easy, as the patient is quite afraid and makes a great effort to avoid even the slightest contact with the allergen.

When treating patients as highly sensitized as this, we recommend the individuation of therapy for each patient. Specifically, the amplification of the allergen information should be incrementally increased. Direct application of the allergen to the patient's skin may, in these cases, cause reactions even when the allergen is sealed in a glass vial. We were able to treat our patient without any incidents. The hard part was to convince the patient that after therapy, ingestion of elderberry in any form would no longer cause reactions. Step by step the fear, deeply rooted, eventually dissipated.

Mold Fungi as Ingested Allergens

We already discussed the significance of mold fungi as potent allergens in the chapter on inhalation allergies. In addition, fungi of the same or similar species may occur as contamination in foods. At that point, they can cause considerable difficulties during diagnosis.

Another example:

Patient H. V., born in 1990

We first saw the child at the age of two. At that point, the child had experienced five severe acute symptomatologies displaying generalized urticarial exanthema, Quincke's edema and severe deterioration of general health. In the time between the attacks the child was completely healthy and symptom free.

Initially, a common denominator initiating the attacks was unrecognizable. A colleague placed the child on a restricted diet. Basically, it comprised rice and potatoes. Intense investigation finally pinpointed three foods: white bread (apparently not every kind), certain baby foods, and a specific type of wheat semolina. Any other test results pertaining to wheat, other grains, and all food additives in question were negative. The last attack finally provided an indication. It occurred after eating a small amount of goat's cheese. Subsequent test results using all combinations of mold fungi at our disposal finally indicated a positive result. Further differentiated testing highlighted the mold fungi *Pullularia pullulans* as the definitive allergen. Seemingly, it had contaminated the initially suspected foods. It may have also been present in the home and been introduced into the food in this manner.

Treatment with the individual allergen of this fungus completely healed the patient. No allergic reaction of any kind was ever experienced again.

In one respect, this example illustrates the importance of a subtle diagnosis. Conversely, it indicates the necessity to include a broad spectrum of possibilities when establishing the diagnosis.

Mold fungi allergies are generally on the rise. In the realm of ingestion allergies, this applies particularly to contaminated, often insufficiently stored foods such as bread, any type of pastries, as well as jams, compotes, etc. Basically, any somewhat moist food item may contain mold fungi.

People rarely take into consideration that mold fungi may already be established on the grain before the harvest. In warmer climates, these are primarily the fungi of the species *Aspergillus flavus*, in moderate climates, specifically *Fusaria*. These fungi attack grain (particularly oat, wheat, and corn) in the field. They are mainly considered toxin forming. If pets are fed solely with feed that contains fusaria toxins, they may suffer severe poisoning.

Besides the above-mentioned field fungi, storage fungi also play a distinct role in the case of wheat. They usually inhabit stored grain that has high moisture content. These fungi are primarily of the species *Aspergillus* and *Penicillium*.

A human being eating a relatively varied diet runs a low risk of falling ill with mold fungi toxicosis. However, the risk for anyone allergic to mold fungi is quite high. Particularly in the case of mold fungi, people can be highly sensitized and experience severe allergic reactions.

A further danger for people allergic to mold fungi is the increasing industrial use of so-called **starter cultures** when making a variety of products (e.g., yogurt, cheese, bread, wine, and beer). **Enzymes of mold fungi** pose another risk to anyone allergic to fungi. More and more frequently fungi enzymes are used for the enzymatic degradation. This achieves more favorable properties, for example longer shelf life, flavor, etc. The economic aspect may be reasonable, but for anyone allergic to fungi this creates an increasingly difficult situation.

Allergies to Food Additives

Food additives are *"natural or chemical substances that are added to foods in order to influence their condition or achieve desired properties or effects"* (German Food Law of 1974).

In order to effectively protect consumers from health-damaging additives in their food, a list of all harmless and therefore approved additives was instituted. The members of the European Community agreed on a collective list, assigning numbers to the individual substances. These **E-numbers** (actually EC numbers) were meant to simplify commerce between the individual countries of the European Community. A side effect of this is the information provided to the consumer.

The declared aim of a list containing all approved food additives is the protection of the consumer. In order to be added to the list, a substance has to pass numerous tests, after which it is deemed toxicologically harmless. A normal dose of the substance must not lead to indications of toxicity. It must not damage the genotype, cause cancer or malformations, nor must it negatively influence fertility, etc.

The question arises, does this "safety net" surrounding our food, as the authorities refer to it, indeed improve our nutrition, making it healthier and less risky?

Looking more closely, the law regarding the "**positive list**," that is to say, the list of all approved additives, has been the solution with varying aspects, which brings the term positive into question.

On the one hand, there is concern about lowering the risk of food poisoning in the broadest sense of the word as well as applying numerous methods to the prevention of food spoilage. Conversely, **this law has opened the**

floodgates allowing the commercial manipulation of our food. This fact has become increasingly evident and is cause for concern. Using approved additives, a powerful economic sector generating revenues in the billions worldwide, is busy making our food even better, more colorful, more fragrant, more practical, and extending its shelf life. The degree to which individual foods have been processed and the extent to which they no longer resemble their original state is alarming. This does not concern the producers as long as the goods sell well. This does not solely apply to wholesalers. The chemical industry provides small businesses (e. g., bakers, butchers, confectioners) with a plentiful selection of substances, complete with directions (free of charge), to legally "improve" their goods, making them more competitive. With regard to their daily diet, the consumers, whose protection was the original focus, are ending up in a whirlpool of "approved" manipulation, no longer clear cut and virtually impossible to avoid.

The following table presents an idea of the incredible amount of chemical substances that are added to our food over the course of a year. The data was generated from a report in 1981 by the chemical company Hoechst. It relates to the situation in the Federal Republic of Germany at that time. We can quite safely assume that current figures are a lot higher (for obvious reasons, previous years' figures are no longer available). It is estimated that annually each person in Germany consumes more than 150 kg of food additives!

Annual consumption of food additives (Federal Republic of Germany 1981)	
Food coloring	325 tons
Preservatives	2 300 tons
Emulsifiers	15 870 tons
Sweeteners	1 300 tons
Thickening and gelling agents	15 700 tons
Acidity regulators	44 600 tons
Flavor enhancers	13 380 tons

These facts are twice as weighty for people susceptible to allergic reactions. Even though many of the substances contained in the E-number list are toxicologically harmless, they present an **allergen potential** often significant for people susceptible to allergy, resulting in true allergic reactions as well as pseudo-allergic reactions. (In Part I, we defined pseudo-allergy as a *hyper-*

sensitivity reaction that occurs after reaching a certain threshold of a specific substance. It is a quantitative phenomenon, whereas the true allergy is quantitatively independent. It is caused entirely by the allergen information.)

According to our definition of pseudo-allergic reactions, in the case of food additives, quantity dependent reactions are significant due to the fact that the same substance (e. g., azo dyes, specific preservatives, etc.) may be ingested on the same day via many different foods (Fig. 5.6 is an example of this). Distinguishing between pseudo-allergic reactions and true allergies may be important to understanding some correlations. However, it is of no great practical significance. The delineations are vague. Diagnosis and therapy follow the same rules.

Symptomatology

Food additives are usually chemical substances, only some of which are potential allergens. The **symptomatology** of the allergic reactions they cause is manifold and much more varied than in the case of simple food allergies.

Figures 11.5 to 11.8 on page 168 illustrate typical skin eruptions caused by food additives.

Besides generalized exanthema, strictly localized changes occur that always appear in the same place on the body after each contact with the relevant substance. After ingesting any food containing the yellow food coloring tartazine (E102), the patient in Figure 11.5 always experienced itching papules on the helixes of both ears that disappeared after 1 to 2 days.

Another patient suffered from pruritic papules on both knees for several days after eating a particular smoked sausage (Fig. 11.6). We were able to prove an allergy to sodium nitrite (E250). It is a preservative used as pickling salt, meant to prevent the formation of botulinum bacteria in meat products. The epidermal alterations of the patient pictured in Figure 5.6 (p. 57) always appeared in the same place, the inside of the thigh. In this particular case, it appeared after ingestion of the coloring agent azorubin (E122) exceeded the tolerance limit.

Figure 11.7 shows an exanthema that always appeared after substantial amounts of a certain type of orange juice were consumed. The oranges, originally suspected, turned out to be non-reactive. The origin of the allergy was the azo dye amaranth (E123). Grocery stores, our main shopping venue, as well as modern eating habits are the source of certain food additives, which are ingested daily, or almost daily, as part of our basic diet. If the body becomes sensitive to these substances, neurodermatitis-like symptomatology may very well occur. Figure 11.8 exhibits a chronic exanthema that had been present for many weeks. The patient's dermatologist diagnosed it as neurodermatitis. It is, in actual fact, an allergy to a preservative,

Fig. 11.**5** Localized allergic reaction to tartrazine (E102). Itching papules on the helix of both ears.

Fig. 11.**6** Localized allergic reaction to sodium nitrite (E250) found in a specific brand of sausage.

Fig. 11.**7** Allergic exanthema caused by the red colorant amaranth (E123).

Fig. 11.**8** Allergic reaction to PHB ester, E214. Similar symptomatology as for neurodermatitis caused by daily ingestion of this substance contained in assorted foods.

parahydroxybenzoic acid ester (PHB ester, E214). This substance is commonly used as a preservative in many different foods. We found that several of the foods ingested daily by the patient contained the preservative E214.

Substances

The E number list divides the substances into categories. Only the most significant substances that are commonly known to cause allergies are mentioned.

Approved Food Coloring and Dyes (E100–180)

Coloring and dyes are used in the food industry exclusively for the purpose of selling the product. Generally, this is not a bad thing—no consumer likes to buy pale and unappealing food—except for the fact that among the colorings and dyes are a myriad of substances that are strongly allergenic.

Specifically, the azo dyes (E102, E104, E123, E124, E132, E133) are important allergens. In the past, the yellow food coloring tartrazine (E102) was the most significant. For many years, E102 was by far the most frequently used chemical food additive. Due to its strong allergen potential, it was finally banned. However, the replacements, the yellow colorants E104 and E110, are barely less potent allergens than tartrazine. Allergic reactions comprise various types of skin rashes as well as general symptoms such as temporary fatigue, gastrointestinal problems, etc. We observed a noticeable weight increase in a patient in excess of 2.2 lb (1 kg) a day after ingesting tartrazine (Fig. 11.9).

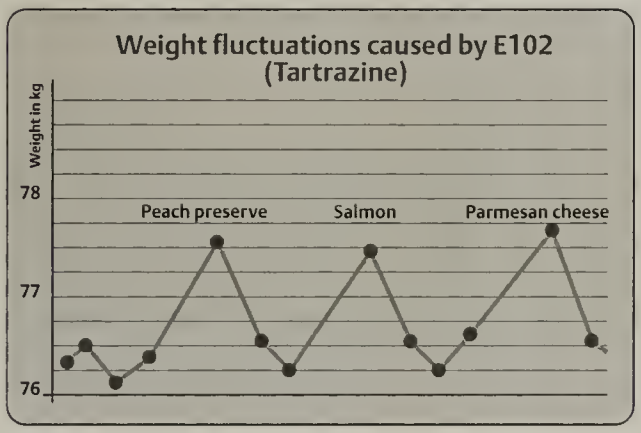

Fig. 11.9 Weight fluctuations in the case of tartrazine allergy (E102). After each ingestion of tartrazine-colored foods a significant weight increase in excess of 2.2 lb (1 kg) is recorded.

Different types of foods containing the coloring agent tartrazine were not marked as such; hence, identification was impossible. Today, we can assume that all foods that are to some degree naturally yellow or orangey red have been colored with azo dyes, specifically tartrazine

Important in practice are the correlations between allergies to azo dyes and **hypersensitivity to salicylic acids**. More than half of all patients intolerant to aspirin and other derivatives of salicylic acids also react allergically to tartrazine and other azo dyes.

Typical products containing azo dyes are: any type of sweets, canned fruit, sodas, pudding, ice cream, liqueurs, margarine, cheese and fish products. Azo dyes are even used to color medicine, sometimes to make it easier to distinguish, sometimes for optical reasons. We know of several cases of an apparent allergy to medicine that turned out to be an allergy to the coloring agent contained in the medicine.

Preservatives (E200–290)

Preserving food is one of the most important reasons why chemical substances are added to food. The traditional preservatives known to every homemaker such as sugar, salt, vinegar, and alcohol are no longer practical or sufficient to provide consumers with the diverse range of food products they are accustomed to these days. In particular, off-the-shelf products requiring chemical preservatives are becoming increasingly popular. The additives are intended to prevent the propagation of mold fungi, fermentation, and putrefaction-inducing bacteria. In this way, they are a blessing unless they create allergic reactions. Among the many approved preservatives (E200–290), the following are potential antigens:

- Sorbates (salts of sorbic acid E200–202).
- Benzoates (esters of benzoic acid E210–213).
- PHB esters (parahydroxybenzoic acid esters in various chemical variants, E214–219).
- Sulfites (esters of sulfuric acid E220–227).
- Nitrites and nitrates (E250–252).

Particularly important in this group are the **PHB esters**, which include ethyl, methyl, and propyl esters of parahydroxybenzoic acid. (E214–219; trade names: paraben, nipagin, nipasept, solbrol, etc.). Besides being used in a variety of food products such as canned vegetables, seasonings, marinated fish products, salad dressings, jams, and fruit juices, they are also added to many cosmetics items, such as salves and creams. These are mostly found in the form of a combination of different esters. They have considerable allergic potential. Allergic reactions usually manifest as skin conditions such

as urticaria and eczema (see Fig. 11.8). A sensitization to PHB esters can cause or worsen a local nickel allergy (e. g., to fashion jewelry, watch straps, dress straps).

Cross-allergies to other para-compounds such as sulfonamides, procaine hydrochloride, etc., are also common. Many patients who are sensitive to salicylic acid show allergic reactions to derivatives of benzoic acid.

Sulfites (E220–227) are used in sulfured dried fruit as well as in dry potato products, jams, juices, many different types of wine, etc. In many instances, substantial amounts are added to foods. Asthma patients, in particular, often react allergically (**sulfite asthma**). It is highly interesting that many of these patients also report a higher sensitivity to smog.

Nitrites and **nitrates** (E250–252) are primarily used for extending the shelf life of meat products (pickling salt). Allergic reactions are rare, but may be cumulative and should be observed (Fig. 11.7). There are always new developments, particularly in the field of preservatives. The chemical industry regularly introduces new substances. Initially, after a toxicological test, these are admitted to a "positive list" which makes them part of the approved additives. They do not receive their individual E number until much later. As yet, the possible allergen potential of these substances is unknown. Only the results after several years of use will allow us to draw certain conclusions.

A typical example is the new preservative **kathon-CG** (euxyl). Over the course of recent years, this substance has been used specifically in the preservation of cosmetics. It has already been admitted to the "positive list." Judging by previous experience, it seems to have considerable allergen potential (kathon-CG was included in the food additives test set in the summer of 1992).

A special group of preservatives are the **surface preservatives**: Biphenyl (diphenyl) = E230; orthophenylphenol = E231; sodium orthophenylphenate = E232; thiabendazol = E233. They are used on the skin of citrus fruits. Consequently, they may appear in jams and preserves made from these fruits.

Antioxidants

Few substances in this group are potential allergens: The alkyl salts of gallic acid, the gallates propyl, octyl, and dodecyl (E210–212), are primarily used as antioxidants in fats and vegetable oils. They are also found in margarine, instant food items, potato products, and chewing gum. People with asthma or sensitive to salicylic acid may react allergically. The same goes for the chemically similar substances butylated hydroxyanisole (BHA) = E320 and butylated hydroxytoluene (BHT) = E321. They are often combined with gallates and phosphates to prevent food from becoming rancid. They, too, are found in many convenience foods, sweets, margarine, bouillon cubes, etc.

Emulsifiers

Emulsifiers are substances that make it possible to mix other substances that ordinarily are not homogeneous, for example oil and water. They are often used to introduce water, which is cheap, into foods (e. g., meat products). Medically interesting in this group are primarily the different **phosphates** (E338–341, E450, E544, E545). Their effect on sensitive people, allergenically speaking, is of a more quantitative, accumulative nature rather than a true allergic reaction. Among other things, they are blamed for the **hyperactivity syndrome in children.** In our experience, hyperactive children are a rather heterogenic group. In only about half of the cases is hypersensitivity to phosphates the deciding factor. In those cases phosphate, occurring naturally in food, cumulates with the phosphoric sodium in the form of stabilizers, emulsifiers, rising agents, color enhancers, etc. which are often plentifully added to food. The percentage of phosphates in food has increased by more than 300% over the course of the last 30 years!

Among these are the various salts of orthophosphoric acid (E338–341) and the sodium, potassium and calcium salts of phosphoric acid (di-, tri-, tetra-, penta-, and polyphosphates (E450a, b, c, E544, 545). Typical products containing phosphates include cheese (e. g., Emmentaler), condensed milk, powdered milk products, bread, baking powder, frozen fish (fish sticks), canned sausages.

Flavor Enhancers

Flavor enhancers by themselves do not have any taste. However, by stimulating the taste buds they enhance a food's inherent aroma.

Typical representatives of this group are the **glutamates** (sodium, potassium, calcium salts of glutamic acid [E620–623]). They are commonly used in ready-to-eat foods, soups, sausages, and above all, monosodium glutamate, typically found in dishes of Chinese cuisine. People sensitized to the relevant substances may experience the characteristic symptoms of palpitation, dizziness, headache, and weakness. This is now commonly known as the **Chinese restaurant syndrome**.

Aromatic Essences and Extracts

The artificial aromatic essences and extracts that the food industry uses ever more frequently still fall under the criteria "must not be damaging to health." Consequently, they are not included in the E-number list and do not have to be listed individually on the food packages.

g. 11.**10** Allergic exanthema to paratamol.

Fig. 11.**11** Allergic exanthema to trimethoprim.

g. 11.**12** Allergic exanthema to amoxyllin.

Fig. 11.**13** Allergic mucous membrane reaction (Stevens–Johnson syndrome) to a cephalexin preparation.

Therapy

The introduction of **therapy methodologies without avoidance** of the allergen significantly improved and simplified therapy possibilities. This also holds true for allergies to food additives. Avoidance of the allergen, imperative in the past, was extraordinarily difficult in the case of chemical food additives. Too many foods have been chemically altered today. Consumers cannot rely on all ingredients being declared on the packaging.

The ampoules in the food additives test set can be used for therapy. For detailed information regarding the individual substances, consult the book *Die Testsätze nach Dr. P. Schumacher* (Test Sets According to Dr. P. Schumacher).

Allergies to Medications

Allergies to medications are *"unwanted, unexpected reactions to a medication administered in clinically accepted dosages"* (Ring 1982). They are definitely on the rise. Severe symptomatology, including anaphylactic shock, is common in this group. Parenteral administration by injection or infusion significantly increases the danger. Essentially, every medication can be an allergen. However, some groups of pharmaceuticals are more risky than others. Among these are the antibiotics derived from mold fungi such as penicillin, ampicillin, erythromycin as well as sulfonamides, antipyretics, and antirheumatics.

Symptomatologically speaking, besides symptoms of the intestinal tract, skin rashes are in the forefront, often severe. Some typical examples from the practice are illustrated in Figures 11.**10** to 11.**13**.

In order to diagnose allergies to medications, allopathic medicine usually has to rely on anamnesis and very risky provocation testing. Here, too, the physical diagnostic methodologies are far superior in every aspect. Any suspected medication brought to the office can be tested immediately on the patient (or even by using a drop of the patient's blood) without any risk.

Once again, diagnosis is the foundation for therapy. The medication itself is used for the treatment. Even for the most susceptible patients, its physical frequency information, inverted and amplified using the BICOM technology, precipitates the immediate elimination of the allergy without side effects.

12 Neurodermatitis

Statistically, neurodermatitis (also called atopic dermatitis, chronic constitutional eczema, etc.) is one of the most common skin diseases, occurring primarily in childhood and adolescence. Examinations show there has been a significant increase in cases of neurodermatitis in recent years. According to a study by Schöpf (1992), the occurrence of neurodermatitis in children increased from 3% in 1960 to above 10% in 1992. Przybilla found incidences of 13.2% in the case of preschoolers in Bavaria.

The disease often begins in infancy or early childhood, is of a chronic and/or chronically recurring nature. It frequently lasts for many years, even decades.

Pathogenesis

It has been common knowledge for many years that neurodermatitis belongs to the atopic allergies. Traditionally, the term **atopy** comprises the congenital and inherited susceptibility to be sensitized to specific allergens. Subsequent reactions include clinical symptomatology such as hay fever, allergic asthma, and neurodermatitis. Sixty percent of all neurodermatitis patients also suffer from other atopic diseases. In the case of identical twins, the figure is 85%, for fraternal twins 30% (Schultz-Larsen 1985).

If one of the parents is affected, one-third of the children can also be expected to become atopic. If both parents are affected, two-thirds of the children may become atopic.

Even though neurodermatitis displays one of the highest IgE serum values with all indications pointing toward an allergic genesis (including clear relations to atopy), **the role of allergy in the development of neurodermatitis has been significantly underestimated.**

Vaguely mentioned is the fact that there has to be an additional trigger, a provocation factor besides the genetic disposition. Rather than considering an allergy as the trigger for the exacerbation, numerous exogenous factors are suspected such as textiles, laundry soap, and inhalation allergens (e. g., house dust mite, animal epithelia, pollen) or endogenous, primarily psychological, factors and nonspecific skin irritations (e. g., rubbing and scratching).

Overall, allopathic medicine remains baffled when it comes to understanding neurodermatitis. Numerous speculations as to the pathogenesis as

well as a multitude of different therapy approaches prove this. Despite much effort and many highly endowed research projects worldwide, neurodermatitis patients are still being repeatedly told: *"You will have to live with neurodermatitis. It may abate at some point by itself but generally remains incurable. Anyone who claims the opposite is a quack."*

As for us, we are happy to provide our patients with a much more optimistic prognosis. Experiences in recent years, the results of several hundred neurodermatitis patients successfully treated in our practice, coupled with the reports of many other bioresonance physicians, are clear.

Our current attitude to neurodermatitis can be summarized as follows:

- Neurodermatitis is purely an allergic disease.
- Prior to its development is a frequently strong susceptibility to allergies that is congenital and inherited.
- The original cause is always a chronic, in most cases, masked allergy to one or several staples. By far the most common allergies are to **milk** and **wheat** or both. Allergens continuously present in the body may cause similar symptomatology (allergy to candida fungi with concurrent candida mycosis of the intestine or mercury allergy in the case of amalgam fillings in the teeth).
- A cure is possible if the chronic allergic mechanism is interrupted successfully and the central allergy completely eliminated.

Our definition is quite contrary to the current scientific point of view. Yet, our ideas are not based on theoretical hypotheses. They are exclusively based on the provable, experiential data gleaned from our practice. By undergoing our therapy for a few weeks, any neurodermatitis patient will believe in the validity of our statement.

Crucial to the understanding of a chronic allergy, including neurodermatitis, is the phenomenon of **masking**.

Masking of an allergy signifies that there is no noticeable correlation between contact with the allergen and the type or severity of the symptoms (as in the case of neurodermatitis eczema variances).

That is to say, there is no immediate exacerbation of the skin condition if someone allergic to milk eats a lot of cheese or curd. The same goes for someone allergic to wheat choosing to exist on a pasta diet while on vacation.

Masking does not mean that patients should eat as much as possible of their masked allergen in order to be symptom free. **Anyone suffering from neurodermatitis who is at the stage of allergen masking lives under se-**

vere, **constant stress**. The severity of his/her skin condition largely depends on how well the organism manages to compensate for the continual allergic stress. Therefore, all additional stressors, whether physical or psychological, act as triggers for exacerbation. These include diseases in the remote sense of the word such as toxicological, geopathic or focal stressors, and particularly psychological tension and conflict situations.

On the contrary, many neurodermatitis patients are aware that their skin improves significantly in times of general relaxation, when on vacation for example. Books and other publications dealing with neurodermatitis are brimming with advice to this effect. Any type of **release** the organism experiences may improve the neurodermatitis and may have a calming effect on its course and/or severity.

However, true healing is only possible if the cause of the disease—the allergy—is eliminated!

It is imperative that the **allergen** (as previously mentioned, usually cow's milk protein or wheat, or both) is recognized as such and completely eliminated from the diet. This effects a **de-masking** of the allergy after 4–5 days at the most! Once the allergen is de-masked and recognized, from that day forward the minutest trace of the allergen will lead to a distinct skin reaction with increased itching and worsening of the eczema.

Besides chronic allergies, which are always the source of neurodermatitis, the same patient also experiences **imposed acute allergies**. They may be caused by various foods (e. g., citrus fruit, tomatoes, chocolate). They may change during the course of the disease; that is to say, they appear and disappear causing an exacerbation of the skin condition. Yet, they are never the actual cause of neurodermatitis. Substances that affect the skin topically (e. g., ointments, cosmetics, textiles, laundry soap) may act as acute allergens. The same situation applies for them, as did for the acute food allergens.

The severity of the skin condition is individual to each case. It also varies considerably during the progression of each case. It depends on the **extent of the sensitization** as well as the **patient's overall current constitution**. That is why symptoms may improve on vacation and worsen significantly during times of stress, psychological stressors, etc. Contrary to the opinion of many proponents of psychosomatic medicine, the **psyche is not the cause for neurodermatitis**. Rather it is one of several possible, often quite influential, **factors effecting destabilization**!

Patients suffering from severe chronic neurodermatitis frequently have **multiple allergies**, that is to say, they react to many different stimuli that

are almost undetectable. Nevertheless, the **hierarchy of allergens** applies to these patients:

> The central allergen (milk or wheat or both) is always the most important and the actual cause of the allergy.

The other acute, superficially imposed allergens, as numerous as they may be at times, merely act as modifiying or destabilizing factors. At best, their elimination may bring certain relief, but never true healing!

Progression

Commonly the disease begins during the first year of life. According to a French study involving 300 children, 38% of all neurodermatitis patients displayed the initial symptoms within the first 3 months of their lives, 26% between 3–6 months, and 16% between 6–12 months of age (Queille and Saurat 1981).

Certain types of neurodermatitis begin much later. Generally, their prognoses are more unfavorable.

After several years, neurodermatitis in children may (though not necessarily) disappear on its own. Even for patients where there seems to have been complete remission, it is not uncommon for small lichenified lesions to appear in the flexures of the joints and on the hands once they begin school.

A number of detailed studies have been carried out regarding the long-term prognosis. Rystedt's study published in 1985 is probably the most compelling of all: Rystedt examined about 1000 people ranging from 24 to 44 years of age, who had had neurodermatitis since childhood. Sixty-two percent of those with severe neurodermatitis during childhood and 40% of mild neurodermatitis cases continued to display cutaneous symptoms, mostly on the hands.

Of course, all studies published refer to cases that were treated according to the theories of allopathic medicine at that time. Epidermal care was the primary treatment method including the use of topical preparations containing corticoids and oral or parenteral administration of corticoids.

Understandably, our experiences regarding the course and prognosis of neurodermatitis are completely different. When we realized that neurodermatitis in all its forms is almost always based on a chronic food allergy, the course and prognosis for our patients changed dramatically.

Clinical Symptomatology

Eczematous eruptions on the skin and a constantly present intense pruritus are the common denominators for all phases and types of neurodermatitis.

There are distinct differences in the location and efflorescence that clearly indicate the causal allergen. This realization was a surprise for us. Initially, the improved testing methodologies for food allergies provided a symptomatology that had been unheard of worldwide, even though it is obviously quite common. It is the **neurodermatitis resulting from an allergy to wheat protein** (not to be confused with the commonly known allergy to gliadin, the cause of celiac disease!).

Wheat itself has been known strictly as an inhalation allergen in the form of flour, causing chronic-allergic baker's asthma (Woitowitz 1983, Popescu et al. 1981, Theobald et al. 1983). Nobody suspected a correlation with the classic symptomatology of neurodermatitis. Consequently, we were amazed when we found that in a large percentage of patients generally diagnosed with neurodermatitis the actual cause of the neurodermatitis was a wheat allergy.

Meanwhile we were able to recognize a very typical, clearly delineated dermatological symptomatology. It displays the general criteria of neurodermatitis, but due to localization and efflorescence of the skin changes, an autonomous syndrome is recognizable.

Wheat Neurodermatitis

Allergen-specific peculiarities are somewhat unusual in the case of allergic symptomologies. Hay fever remains hay fever, no matter which pollens may cause it. The symptoms caused by an allergy to animal epithelia, an acute food allergy, etc. seldom allow us to conclude which type of allergen we are dealing with.

This is different in the case of neurodermatitis resulting from a chronic food allergy. Usually, both allergens in question, **cow's milk** and **wheat**, create very specific and individuated symptoms that any expert will be able to correctly diagnose in a patient right away.

In the case of a chronic wheat allergy, primarily the **face** and **distal region of the extremities** display the unmistakable signs of the allergy.

Mainly affected in the facial area are eyelids and perioral region. Figures 12.1–12.4 on page 180 illustrate typical examples.

The **eyelids** are swollen, infiltrated, and often display marked creases. In dermatology, creases on the lower eyelids are commonly known as the stig-

Figs. 12.1 to 12.4 Faces affected by wheat neurodermatitis. Infiltration and the appearance of irritated creases on the eyelids in combination with eczematous changes are typical; often they are just impurities in the perioral region.

ma of neurodermatitis patients; these creases are called Dennie-Morgan lines or folds after the scientists who first identified them..

In older children and teenagers, a prolonged course of the disease frequently leads to severely lichenified regions around the eyes, eventually creating the impression of a mask-like face. We are often reminded of the eyes of an elephant. Besides itching and the constant feeling of tightness, these changes frequently stress these young patients psychologically. They cannot be concealed and usually lead to the patients' increasing isolation from their peers.

The concurrent changes in the **perioral region** can be manifold. In this case, localization is typical, not the type or severity of the changes. Sometimes the red tone of the lips appears slightly delineated in an unusual way. Sometimes eczematous lesions are present directly where the skin and mucous membrane interconnect. Occasionally, they are found in other areas of the perioral region. Rarely are the lips themselves directly affected. After a while, they

gs. 12.5 and 12.6 Changes on the skin of the neck in the case of wheat neurodermatitis. filtration and lichenification of the skin are in the foreground. Thickening of the skin and e appearance of multiple creases.

may swell or become chapped. Another typical site of chronic wheat allergy is the neck. Younger children commonly experience intense itching; the skin itself barely changes in appearance. If this goes on for an extended period of time, the skin will thicken and become lichenified (Figs. 12.5 and 12.6).

Xerosis, infiltration, and lichenification generally characterize the skin changes of a wheat neurodermatitis. Conversely, cow's milk neurodermatitis, which we will discuss next, primarily displays exudative symptoms. Pathognomonic for wheat allergy are the eczematous changes on the **hands** that usually appear lichenified and rather dry. This occurs almost exclusively on the flexural side of the wrist and on the tops of the hands (Fig. 12.7). Intense itching often leads to scratching (Fig. 12.8).

The symptomatology of chronic focal eczema in the flexures of the arms is primarily exhibited in cow's milk neurodermatitis (see Figs. 12.24–12.27). It may also occur in the case of wheat allergy. These changes tend to be rather dry and lichenified as well (Figs. 12.9 and 12.10). The itch can be considerable. Generally, though, it is not as intense as in the case of eczema in the flexures of the extremities caused by cow's milk.

The lower extremities are, as a whole, implicated much less frequently. If at all, the distal regions are preferred.

The **onset of the disease** usually occurs after infancy, approximately at the age of two or later, sometimes in adulthood. We have not observed any sensitizations passed on through breast-feeding, as can occur with a cow's milk allergy.

Overall, wheat neurodermatitis displays extraordinarily characteristic and individuated symptomatology, summarized as follows:

Symptomatology of wheat neurodermatitis

- Onset usually at the age of two or later.
- Pathognomonic localization to be found in the face and distal region of the extremities.
- On the face, the ocular and perioral regions are usually affected. With regard to the extremities, especially the distal region of the forearms and the tops of the hands are affected. Eczematous changes in the flexures of the joints occur, yet tend to be rare.
- Skin changes are primarily dry and lichenified.

Meanwhile, we have known in excess of a hundred cases that displayed this unmistakably distinctive symptomatology. Successful therapy proved our accurate diagnosis in each case.

The example on page 184 (Figs. 12.11 and 12.12) clearly demonstrates that a young person can be spared much suffering. Accurate diagnosis and

gs. 12.7 and 12.8 Localization in the extremities, typical for wheat neurodermatitis. Eczeatous changes on the distal region of the forearms and the tops of the hands concurrent th the changes in the face are almost pathognomonic for the chronic allergy to wheat proin.

gs. 12.9 and 12.10 Eczema on the elbow in the case of wheat neurodermatitis. The flexes of the joints are implicated less often by a wheat allergy. Here, too, thickening and infilation of the skin are in the foreground.

Fig. 12.**11** Wheat neurodermatitis. Typical eczematous changes in the face that have existed for several years (ocular and perioral regions).

Fig. 12.**12** Patient in Figure 12.**11**, healed.

appropriate therapy make it possible to heal such an acutely stressful disease as neurodermatitis.

Previously we mentioned that **oligosymptomatic forms** of chronic wheat allergy exist. Commonly the skin is "dry," sometimes it itches and sometimes it does not. Scientific medicine is well aware of the term atopic xerosis as an expression of infra-clinical eczema (Uehara 1985), even if it is not in conjunction with an allergy to wheat protein. A particular symptomatology known as **juvenile plantar dermatosis** in dermatology also appears to be interconnected with chronic wheat allergy. In 1985, Ashton and coworkers described this disease as an autonomous syndrome. The clinical symptomatology is typical. The changes are exclusive to the anterior plantar surface. The skin is dry and often displays a strange collodium-like appearance. Particularly on the plantar side of the big toe, rhagades are common. They heal with great difficulty.

Usually this symptomatology is confined to older children and teenagers, disappearing during adolescence. So far, the etiology has been completely unidentified. In the case of existing atopy etc., allergic influences caused by the material of shoes were under discussion.

We are already aware of several cases in which a correlation to a chronic wheat allergy can be clearly proven.

The following **example** illustrates this:

Patient O. C., born in 1981

The patient came to our practice at the age of eight. For several years, he had suffered chronic eczema in the upper third of both plantars, specifically on the big toes. Repeatedly, painful rhagades (Fig. 12.**13**) appeared. Despite numerous therapy attempts, consistent improvement was unattainable.

Allergy testing identified an allergy to wheat protein. For the first time in years, the skin condition improved significantly following avoidance of the allergen (Fig. 12.**14**). Unintended, the boy ingested a wheat wafer (his first

g. 12.**13** Juvenile plantar dermatosis. is clearly defined symptomatology also oved to be due to a chronic wheat allergy.

Fig. 12.**14** Improvement after 3 weeks of avoiding wheat.

Fig. 12.5 Relapse after eating a minute amount of wheat. The patient received a wafer containing wheat in church. Immediate exacerbation of the eczema occurred.

communion) which lead to immediate exacerbation of the eczema (Fig. 12.15). After renewed avoidance of the allergen and subsequent allergy therapy, the eczematous condition healed. The symptoms have not recurred.

Cow's Milk Neurodermatitis

Neurodermatitis due to a chronic allergy to cow's milk protein also displays typical, for the expert unequivocal, characteristics:

Onset already evident in early infancy:
The first changes in the skin frequently appear in the first weeks of life. Initially, they are almost exclusively confined to the facial region. Specifically, the convex areas of the face (cheeks, forehead, chin) are affected whereas the perioral and ocular regions are not.

The changes present a picture of an acute, red exudative eczema and vesicles, tending to be wet and crustaceous. Figure 12.16 illustrates a **typical example:**

Patient M. D., born in 1989

The child is of an atopic family. From birth, the mother was never able to breastfeed the baby. The disease began quite rapidly in the third week of life. Initially, only the face was affected. Later on, it extended to the upper thorax. Due to intense itching, the child was very restless. Ointments containing corticoid brought temporary improvement.

We saw the child for the first time at the age of 3 months (Fig. 12.16), diagnosed cow's milk allergy and began immediately with strict avoidance of cow's milk, to the point of banning it from the family home. It was replaced with a soymilk diet.

The skin improved after only a few days. Figure 12.17 shows the child 1 month later. The skin cleared up, the child was no longer agitated. At this point, his charm and intelligence had a chance to shine through. After subsequent milk therapy (inverse therapy using the allergen cow's milk protein), the child was able to tolerate a normal diet. He was healthy and remained so over the course of the following years.

In the case of young babies, it is sometimes difficult to delineate between a true neurodermatitis and **infantile seborrhoeic dermatitis and/or cradle cap**. A typical dermatosis affecting infants, it displays greasy, scaly, nonpruritic skin changes specifically on the head and behind the ears. It may also involve various skin creases in the groin and genital areas. No allergic cause can be ascertained. Yet, it clearly correlates in some way to candida mycosis of the intestine.

The result of the allergy test yields a clear differential diagnosis.

A positive test to cow's milk protein proves the existence of a cow's milk dermatitis. If it were true seborrhoeic dermatitis, this test would always be negative.

Evidence of candida fungi in the stool is not sufficient criteria for a different diagnosis. A candida mycosis of the intestine is common in both diseases. Later, we will discuss in detail its importance with regard to neurodermatitis.

The role of cow's milk as the cause of a neurodermatitis is always doubted in the case of exclusively breastfed babies who have never ingested cow's milk in any form. Yet, we know numerous cases of clear and proven **sensitizations via mother's milk**, leading to a cow's milk neurodermatitis in an exclusively breastfed baby.

For a proficient tester, the diagnosis is easy: The child tests positive to an allergy to cow's milk **and** to the milk of his/her own mother. If the mother strictly avoids cow's milk, the test results are negative after a few days. At the same time, the skin disorders heal (unless there is an additional mycosis of the intestine).

Fig. 12.16 Baby displaying typical cow's milk neurodermatitis.

Fig. 12.17 Patient in Figure 12.16, healed.

Fig. 12.18 Nummular eczema due to cow's milk neurodermatitis, typical for older infants and small children.

Fig. 12.19 Patient in Figure 12.18, healed.

While the mother continues to avoid cow's milk, the child can now be breastfed again. Simultaneously, we conducted allergy therapy using cow's milk allergen. If the test to cow's milk allergen is negative after therapy, the mother can use cow's milk again. The child is now able to tolerate the mother's milk as well as any additional food that may contain cow's milk.

Typical plaque-like eczematous changes in small children:
In the case of older infants and small children, cow's milk neurodermatitis is commonly called **nummular eczema**. It presents a strange, but quite characteristic symptomatology.

It forms clearly demarcated, coin-shaped patches (nummular means coin in Latin) on the skin, otherwise unchanged. The preferred site is the trunk. Frequently, the changes appear symmetrically (Fig. 12.18). If the face is involved, ocular and perioral regions are typically unaffected (Fig. 12.20).

As with all skin symptoms of neurodermatitis, the changes of the nummular eczema are also primarily therapy resistant. At best, applying corticoid ointments may bring temporary improvement. Lasting healing is only possible when eliminating the central allergy mechanism. Strict avoidance of cow's milk and allergy therapy using the inverted oscillation of the cow's milk antigen will achieve this result (Figs. 12.19 and 12.21).

If the patient comes into contact with the allergen during the avoidance phase, the eczema that has already started healing may recur, frequently displaying a strongly exudative characteristic. Figure 12.22 illustrates such a reaction. The child ate a small amount of sauerkraut during the avoidance phase (whey was used to make the kraut).

Without successful biophysical therapy, nummular eczema will turn into the classic form of cow's milk neurodermatitis as seen in adults, the flexures of the joints being the preferred sites. In rare cases, the disseminated focal characteristic may last into adulthood (Fig. 12.23). The stationary localized eczema on the inside of both thighs documented in Figures 12.55 to 12.57 is also part of this group.

The larger joint flexures are primary sites for older children and adolescents:
In an older child, neurodermatitis typically appears as chronic, strongly pruritic eczema, symmetrically arranged. It is primarily localized in the flexures of the extremities. Specifically, the flexural regions of the elbows and knees are pathognomonic sites (Figs. 12.24–12.26).

On the forearm and wrist, the changes also primarily affect the flexural regions (Fig. 12.27). In severe cases, the skin of the entire body may be af-

Fig. 12.**20** Typical nummular plaques caused by cow's milk neurodermatitis in an older infant. Ocular and perioral regions are not affected.

Fig. 12.**21** Patient in Figure 12.**20**, healed.

Fig. 12.**22** Cow's milk neurodermatitis in a small child. An acute reaction occurred after ingesting whey following a period of strict avoidance. (The child ate a small amount of sauerkraut made with whey.)

Fig. 12.**23** Plaque-like eczema in an adult, a rare manifestation of cow's milk neurodermatitis.




gs. 12.**24** to 12.**27** Typical sites of cow's milk neurodermatitis in older children are on the unk and the flexures of the extremities. Preferred sites are the flexures of the joints.

Figs. 12.28 and 12.29 Severe form of cow's milk neurodermatitis affecting the entire body. Patient, healed.

flicted. Figure 12.28 clearly illustrates the terrible suffering these patients go through. Since the first month of life, this child had cow's milk neurodermatitis (patient S. F., born in 1988). Having no hope of finding help, up to this point, the entire family was desperate. Too many attempts had been made in vain.

Figure 12.30 shows the same child several months later after strict avoidance of cow's milk and biophysical allergy therapy. The skin has healed completely. Previously dystrophic, the child's general condition has noticeably and significantly improved.

Retrospectively, in comparison to the previously discussed wheat neurodermatitis, cow's milk neurodermatitis also displays clearly characteristic phenomenology. Anyone who is somewhat proficient should be able to distinguish between these two symptomatologies at first sight.

Symptomatology of cow's milk neurodermatitis:

- Onset commonly occurs in the first few months of life, displaying partially wet, crustaceous eczematous changes on the head and face. The ocular and perioral regions are not affected. Breastfed babies are often sensitized via the mother's milk.
- Plaque-like (nummular) eczema is common in older infants.
- In older children, the flexures of the extremities are the primary sites. Pathognomonically, chronic eczema appears in the flexures of the large joints.
- Initially, skin changes are exudative. Lichenification occurs later as a result of scratching, rubbing, and therapy attempts.

Of course, the allergy test is the easiest and safest way to distinguish these two basic types of neurodermatitis. In any case, the characteristic topography of the eczematous changes—the facial area and distal regions of the extremities in the case of wheat allergy, trunk and flexural regions in the case of cow's milk allergy—are important indicators.

A Combination of Wheat and Cow's Milk Neurodermatitis

Genetically predisposed people (almost always atopics) may experience **sensitizations to both cow's milk and wheat protein**. In the second year of life or later, a wheat allergy usually imposes itself onto an initially existing cow's milk neurodermatitis. The relevant symptomatology is quite severe and very stressful for the patient. Both types of allergies can be easily recognized in the same patient.

Patient F. B., born in 1989

The child comes from a family of atopics. Several cases of neurodermatitis exist on the mother's side of the family; pollinosis on the father's side. A few weeks after birth, eczema appeared on the child's facial cheeks; a little later typical eczematous changes occurred in the flexures, thorax, and stomach. In the second year of life, additional lesions occurred, perorally and to a greater degree on the distal regions of the forearms and wrists. The child had been in clinical treatment several times. The patient had been dosed with plenty of corticoids without any lasting improvement.

We saw the child for the first time at approximately 2.5 years of age. We found typical symptoms of cow's milk neurodermatitis with the relevant eczematous changes in the flexures of the arms and the trunk region (Fig. 12.**30**). Simultaneously, we recognized the characteristic display of a wheat

Fig. 12.**30** Neurodermatitis caused by a combination of cow's milk and wheat allergy. Eczematous changes on the insides of the arms are typical.

Fig. 12.**31** Neurodermatitis caused by a combination of cow's milk and wheat allergy (same patient as in Fig. 12.**30**). The perioral region and distal region of the forearms and wrists are typical sites of chronic wheat allergy.

allergy, affecting the distal regions of the forearms and wrists, including discrete perioral lesions (Fig. 12.**31**).

As expected, allergy testing indicated an allergy to cow's milk protein as well as wheat. After strict avoidance of the allergens, both allergies were eliminated (first milk, then wheat). The skin cleared within a few weeks. The child has been on a normal diet for almost 5 years without any symptoms of recurrence.

After a period of months or years, neurodermatitis patients treated successfully may experience a further chronic allergy, displaying the symptomatology of neurodermatitis again. However, true recurrences of the once successfully treated allergen are rare. If they do occur, they are to be treated in the same way as the initial allergy.

Infectious Complications of Neurodermatitis

The skin of a neurodermatitis patient altered by eczema as well as frequent scratching is particularly susceptible to local infections. Known and feared are infections with the herpes virus (Fig. 12.32) and pyogens, specifically *Staphylococcus aureus* (Fig. 12.33). Both cases may develop into a generalized skin condition with severe symptomatology including high fever. Usually, this leads to a considerable destabilization of the dermatosis.

Fig. 12.32 Herpes simplex infection in the case of cow's milk neurodermatitis.

Fig. 12.33 *Staphylococcus aureus* infection (impetiginization) in the case of wheat neurodermatitis.

Neurodermatitis and Mycosis

In the past, we were only able to prove the existence of fungi microscopically or culturally. Once we were able to also identify their specific physical frequency information, our knowledge in this field increased rapidly. This has been of tremendous help in the case of neurodermatitis. We realized that in a high percentage of all chronic neurodermatitis cases superinfections with skin fungi are also present.

This was new to us. However, in recent years, with our paying particular attention to it, it has become an utter certainty. We have coined the term **concurrent mycosis** for these fungal infections. They accompany and complicate the skin changes of a neurodermatitis. Incidentally, our experiences coincide with those of Jones, who found that trichophytin skin tests conducted on neurodermatitis patients returned strikingly positive results (Jones 1980). He called this **atopic chronic dermatophytosis syndrome**. Other authors were unable to confirm dominant fungal infections in the case of neurodermatitis (Hanifin 1980, Saurat 1987). However, their examinations were limited to the culture techniques available at the time which, as is becoming increasingly evident, often result in incorrect negative findings particularly with regard to trichophyton infections. Ever since we have been able to treat the actual cause of neurodermatitis and bring about true healing, it has become increasingly clear that in many cases the pre-existing fungal infection (i. e., the concurrent mycosis) continues to exist and simulates a persistent neurodermatitis, even after the neurodermatitis is cleared up. We call these stubborn mycoses **residual mycoses**.

They usually appear at the same sites as the neurodermatitis (flexures of the joints, neck, hands, etc.). Intensive antimycotic therapy is necessary before they will heal. It is certain that they are no longer a manifestation of neurodermatitis.

Figures 12.34 and 12.35 demonstrate a **typical example**:

Patient P. J., born in 1976
Since the age of two, neurodermatitis, specifically occurring periorally, on the neck and the distal region of the extremities. We diagnosed the patient with wheat neurodermatitis for the first time at age 13. The front of the neck displayed a severely inflamed, pruritic patch (Fig. 12.34). A smear taken from this site revealed trichophyton rubrum (concurrent mycosis).

The patient was instructed to strictly avoid wheat and received elimination therapy. The skin changes disappeared completely with the exception of the aforementioned site on the front of the neck. A small scaly focus re-

Fig. 12.**34** Concurrent mycosis with simultaneous wheat neurodermatitis. Typical, infiltrative skin changes caused by a chronic wheat allergy on the face, periorally, and the neck. A smear taken from the clearly infiltrated portion of the front of the neck revealed *Trichophyton rubrum*.

Fig. 12.**35** Residual mycosis after clearing up of the neurodermatitis. Patient pictured in Figure 12.**34**. After the wheat neurodermatitis cleared up, the skin is smooth and soft. The only site that continues to test positive to *Trichophyton rubrum* is the place on the front of the neck where a small scaly focus remains.

mained, barely circumscribed by a border (Fig. 12.35). Episodic disappearance and subsequent recurrence was evident.

Skin scrapings continued to test positive to the same fungi as before, when the patient was still suffering from neurodermatitis (**residual mycosis**). This focus disappeared only after intensive antimycotic therapy. Figures 12.36 to 12.39 illustrate further examples. In each of these cases, a fungal infection persisted after the neurodermatitis was cured. Strict avoidance of the allergen in combination with allergy therapy removed the allergy mechanism. The true neurodermatitis–related changes disappeared. Skin mycoses remained, simulating a persistence of the neurodermatitis. Even after treating the chronic allergy, the sites of the residual mycosis revealed the relevant allergen: Localization in the flexures in the case of residual mycoses following cow's milk neurodermatitis (Figs. 12.36 and

12.38) and localization on the dorsal aspects of the hands (Fig. 12.37) or in the ocular region (Fig. 12.39) following wheat allergy. The affected areas were usually dry and slightly scaly. Moist rhagades were common (Fig. 12.39) in existing folds of the skin. Usually, these rhagades are especially therapy-resistant.

A culture of skin scrapings revealed almost exclusively the skin fungi trichophyton rubrum. The fungus provokes minimal inflammatory reactions. For decades, according to leading mycologists, it has been the most common anthropophilic dermatophyte (Rieth 1990, Meinhof 1992, and others). Yeast fungi, specifically **candida albicans**, are usually found in moist skin folds and sites of intertrigo. Rarely do they manifest in the drier foci of residual mycoses that follow neurodermatitis.

Candida fungi do play a particularly important role in the intestine of a neurodermatitis patient and must always be taken into consideration.

Intestinal candidosis triggers the skin changes of neurodermatitis. Evidently, proteolytic ferments of intestinal fungi are a potent **provocation and manifestation factor** for the skin changes (Hauss 1990, Meinhof 1976, Menzel 1986, and others).

The biophysical identification test allows us to also accurately diagnose and prove candida in the stool. This made us realize the importance of the intestinal mycosis.

Today we are certain that food allergies are the cause of neurodermatitis, not intestinal candidosis. However, it is a significant trigger for the onset and course of severe neurodermatitis!

For this reason, we examine the stool of each patient during the initial consultation as well as at short intervals thereafter. We consider failing to do so a true medical faux pas. Only the diagnosis and subsequent elimination of the intestinal fungi make our therapy concept possible, which has meanwhile proved valid and effective.

Besides their trigger function (however this may work), candida fungi may act as highly effective **allergens** (Meinhof 1976). Allergic skin reactions to fungal antigens are generally called **mycids**, and allergic reactions caused by candida fungi are called **candidia**. Very likely, this includes the previously mentioned infantile seborrhoeic dermatitis (Menzel et al. 1988) as well as a number of **eczema-like dermatoses** of, to date, unknown etiological origin (Grigoriu et al. 1984).

Fig. 12.**36** Residual mycosis following cow's milk neurodermatitis.

Fig. 12.**37** Residual mycosis following wheat neurodermatitis. The same skin fungi (*Trichophyton rubrum*) were found in the skin changes of the mother's finger.

Fig. 12.**38** Residual mycosis following cow's milk neurodermatitis. The changes at the back of the knees simulate a persistent neurodermatitis.

Fig. 12.**39** Residual mycosis following wheat neurodermatitis. *Trichophyton rubrum* simulates an underlying continuation of the neurodermatitis. A typical rhagade developed in the fold of the eyelid.

Figures 12.40–12.43 illustrate typical examples for these types of mycid eczema. Each of these patients was diagnosed with intestinal candida mycosis. In all cases, the skin symptoms disappeared after successful treatment of the intestinal mycosis and the allergy to candida fungi.

The sensitization to candida albicans is particularly important in the case of current or previous neurodermatitis.

In these cases, the candida allergy evidently follows the already existing path of the neurodermatitis creating a **candida neurodermatitis**.

The Symptomatology of Candida Neurodermatitis

This previously completely unknown disease meets all the criteria of an allergy disease caused by chronic allergies (see Part I). The following are preconditions for its inception:

- The presence of candida fungi in the intestine.
- Sensitization to these fungi, which act as a chronic allergen (due to constant contact).
- The particular type of reaction specific to neurodermatitis must have been imprinted on the organism. This may have occured through an existing or already treated and cured neurodermatitis.

We have observed this particular "path" of a specific type of reaction to various noxae in other allergy–related diseases as well, for example in a hyperreactive bronchial system following allergic asthma or in successfully treated hay fever, if a newly developed pollen allergy creates the same symptoms characteristic for the patient. In some pollinosis patients, the eyes are primarily affected; others regularly display bronchial symptoms or may suffer intolerable sneezing attacks, etc.

The same applies to fully developed candida neurodermatitis. Usually, the "path" that has been imprinted on the patient is noticeable, even if the disease that initiated it has long since passed. For this reason, a recurrence of the previous allergy is the first thing that comes to mind and the effectiveness of the elimination therapy is doubted. Out of several hundred neurodermatitis cases, we have yet to observe a true recurrence of an allergy after a therapy properly and duly conducted, whether in the case of chronic cow's milk or wheat allergy.

Fig. 12.**40** Infantile seborrhoeic dermatitis. Mycid reaction to intestinal candida mycosis.

Fig. 12.**41** Infantile seborrhoeic dermatitis. Mycid reaction to intestinal candida mycosis.

Fig. 12.**42** Vesicular urticarial mycid reaction to intestinal candida mycosis.

Fig. 12.**43** Eczematous mycid reaction to intestinal candida mycosis.

An example:

Patient H. C., born in 1973

A typical case of a candida neurodermatitis following a successfully treated chronic wheat allergy: From the age of 2 years, the patient episodically displayed severe eczematous changes in the face, neck, and hands. She was 18 years old when she came to us. The patient had undergone many therapy attempts, in vain. We diagnosed wheat neurodermatitis showing the typical changes in the ocular and perioral regions (Fig. 12.44). The forearms were also severely affected. Massive levels of candida albicans were present in the stool. Because the patient lived quite a long distance from our practice, we treated the intestinal mycosis with oral nystatin instead of ozone insufflation, the most common treatment of the day. She was instructed to immediately avoid wheat. The smallest mistakes temporarily led to a hyperergic phase. As a result, the patient even had to strictly avoid, periodically, people who were not on a wheat-free diet. Eventually, we were able to conduct allergy therapy using the wheat allergen and the skin cleared up.

After several months, the patient returned with an acute eczematous reaction. Except for her neck, which was severely exudative, her symptoms were identical to those experienced as a result of the wheat allergy (Fig. 12.45). Of course, she assumed a recurrence of the wheat allergy. Allergy testing revealed clear negative results for wheat. However, the test was positive for an allergy to **candida albicans**. As expected, high levels of the fungi were once again present in the stool. We then named the diagnosis **candida neurodermatitis with the clinical symptomatology of a wheat allergy.** Even though strict avoidance of wheat was not necessary this time, within the framework of mycosis therapy, the patient had to completely avoid any ingestion of sugar. We now treated the intestinal mycosis with ozone insufflation and subsequent elimination therapy for candida, which eventually led to the healing of this particular symptomatology as well.

Figures 12.46 and 12.47 illustrate examples of candida neurodermatitis following cow's milk allergy. The eczematous changes of cow's milk neurodermatitis in these patients had already cleared up after therapy. After several months had passed without any symptoms, acute skin eruptions occurred. At that time, allergy testing to food allergens was negative. Test results for candida were positive. In any case, a massive intestinal mycosis was evident. The skin did not clear up until the fungi had been eliminated from the intestine (five ozone insufflations), and allergy therapy using the candida allergen had been conducted.

The skin changes of candida neurodermatitis are usually severe, profound, aggressive, and persistent. Figure 12.48 shows the hands of a child suffering from wheat neurodermatitis. In the course of the disease, sensiti-

Fig. 12.**44** Wheat neurodermatitis with typical changes in the ocular and perioral regions.

Fig. 12.**45** Candida neurodermatitis following cured wheat neurodermatitis. The symptoms of the wheat neurodermatitis are being simulated.

Fig. 12.**46** Candida neurodermatitis following cured cow's milk neurodermatitis.

Fig. 12.**47** Candida neurodermatitis following cured cow's milk neurodermatitis.

Fig. 12.**48** Candida neurodermatitis concurrent with an existing wheat neurodermatitis.

Fig. 12.**49** Candida neurodermatitis concurrent with an existing wheat neurodermatitis.

zation to candida (evident intestinal candidosis) caused extreme exacerbation of the eczematous condition. We have here a candida neurodermatitis, imposed onto a still existing wheat neurodermatitis. Allergy testing indicated positive results for wheat as well as candida. Identical examples are demonstrated in Figures 12.**49** and 12.**50**. The most severe neurodermatitis cases we know are the ones where a candida allergy occurs at the same time as an already severe neurodermatitis. This definitely complicates matters. To bring about the desired therapy result, the intestinal mycosis and the candida allergy have to be treated first. Not until then can any other treatment method be effective. For these patients, the most stressed by neurodermatitis, the experience of complete healing is a particularly joyous event.

Figure 12.**51** pictures the same child as Figure 12.**50**. Several months after successfully concluded therapy of wheat and candida allergies, this child now enjoys life again (Fig. 12.**52**).

Fig. 12.**50** Candida neurodermatitis concurrent with an existing wheat neurodermatitis.

The trigger mechanism of an intestinal mycosis must be recognized in order to distinguish between the imposed candida neurodermatitis and the exacerbated reaction of the existing neurodermatitis. On the one hand, a true allergy to one's own intestinal fungus exists (evidence in the stool and positive allergy test result to candida); on the other hand, the fungi's metabolic products merely destabilize the skin changes (candida positive in the stool; allergy testing is negative).

Many colleagues have attended our seminars over the course of the years and have asked us for advice in difficult cases. Thus, we have had access to a great number of neurodermatitis patients treated in other facilities.

Repeatedly, mycoses and the effects of their manifold expressions in the symptomatology and the course of neurodermatitis create real difficulties and uncertainty. We observe all the time that this important factor does not recieve the necessary attention it deserves and is not taken seriously.

Fig. 12.**51** Candida neurodermatitis with concurrent wheat neurodermatitis (same patient as in Fig. 12.**50**).

Fig. 12.**52** Patient in Figure 12.**51**, healed.

Therefore, we would like to summarize the most important guidelines pertaining to this subject:

Reminders on the subject of neurodermatitis and mycosis:

- Dermatophytes of the species trichophyton rubrum commonly establish themselves (**concurrent mycosis**) in the eczematous changes of a neurodermatitis.
- After healing of the neurodermatitis, focal mycoses remain and simulate an underlying perpetuation of the neurodermatitis (**residual mycosis**).
- **Intestinal candida mycoses** are common in neurodermatitis patients. In severe cases, they are almost the rule. Proteolytic ferments of intestinal fungi are a potent provocation and manifestation factor for the skin changes.

- The basic diagnosis for any neurodermatitis patient should include checking the stool for presence of candida albicans as well as testing for cow's milk or wheat allergy.
- If the stool results are positive, the patient should be treated for the intestinal mycosis first.
- Successful therapy of intestinal mycosis does not prevent recurrences. For this reason, control tests have to be conducted regularly, particularly when the skin condition worsens.
- Sensitization to one's own intestinal fungus is possible and leads to the symptomatology of **candida neurodermatitis**. It may complicate an already existing neurodermatitis and for the most part cause tremendous exacerbation of the skin condition.
- If sensitization to candida occurs after a cured neurodermatitis and simultaneous intestinal mycosis, this can also create a **candida neurodermatitis**. It often wears the mask of the previous allergy (cow's milk or wheat) and simulates a recurrence. Allergy testing for candida is positive in this case. Testing for wheat or cow's milk produces a negative result. Candida is present in the stool.

Therapy

Treating neurodermatitis is not easy, but rewarding. A significant portion of the treatment is in the hands of the patients and their families. Much attention and patience is required. We recommend following the prescribed course of action as closely as possible. It has been tested on many neurodermatitis patients and seems to be the only one that leads to true **healing**.

We already discussed in detail the basic therapy ideas of chronic allergies in the first part of this book (p. 88f.). Whilst we are aware that we may be repeating certain facts, we would nevertheless like to summarize and present an overview of all necessary treatment measures that have proven effective. Without considering these, it is impossible to truly heal neurodermatitis.

Avoidance of the Allergens

Neurodermatitis is caused by a chronic allergy to daily ingestion of a staple. For us, this new realization was the first and most important key to a successful treatment of this disease, still considered incurable.

The logical conclusion is to initially avoid any exposure to the allergen that triggers it. Subsequently, of course, one must eliminate the allergy using one of our proven biophysical methods. Now, we have at our disposal biophysical allergy therapies that make the strict avoidance of the allergen unnecessary. Nonetheless, in severe cases and chronic forms of neurodermatitis it has proven necessary and effective that all contact with the causal allergen be avoided over a period of several weeks.

The longer a neurodermatitis has been active, the more important it is to initially avoid any exposure to the allergen before beginning the actual allergy therapy.

Attempting to circumvent the avoidance of the allergen, which is cumbersome and stressful, and to begin the biophysical allergy therapy at once has lead to tremendous exacerbation of the condition in many neurodermatitis patients. In the case of long-term neurodermatitis, we get the impression that the body initially reacts to the overly abrupt "turning off" of the trigger mechanism initiating a form of panic reaction. Many times, strict avoidance of the allergen is inevitable. Every physician and patient would be well advised to familiarize themselves with this method. The true allergy is a qualitative, not a quantitative phenomenon. That is to say, only the **information** specific to the allergen is important, not the amount. This was already discussed in detail and proven in the first part of the book. It is the second key aspect of a successful treatment of neurodermatitis (see Figs. 7.5 and 7.6). **Allergen exposure on the informational level** must be avoided at all cost. It is insufficient to simply remove, for example, cow's milk (or wheat) from one's diet. The **intangible frequency information** of the relevant allergen must also be taken into consideration. Strict avoidance of the frequency information of cow's milk or wheat presents the actual problem in neurodermatitis therapy. Much attention, almost investigative in nature, is needed to avoid the pitfalls. It is incredibly difficult not to make a mistake (as an aid the patient receives informational literature on cow's milk and/or wheat allergy, which is included in the addendum).

In the initial days or weeks of strict avoidance of the allergen, the skin condition may deteriorate considerably at first. This phase is similar to that of the withdrawal symptoms of an addict. Patience is necessary to get through this phase.

The patient faces particular problems if a **hyperergic phase** temporarily develops. The sensitivity of individuals to their allergens is not an immutable fact. On the contrary, it can vary quite considerably. Various mechanisms (e. g., the previously mentioned de-masking effect) may cause dramatic increases in sensitivity, specifically in patients suffering from chronic allergies.

Therefore, it is important for the patient to be aware of the possibility of a hyperergic phase and to recognize it in time.

Incredibly small amounts of allergen may indeed cause severe reactions in these patients, most of whom are usually afflicted with extremely severe neurodermatitis. Let us recall Smith and his experiments. He demonstrated that in such cases even homeopathic preparations of the allergen, within the realm of completely substance-free high and highest potencies, might cause dramatic allergic reactions. Sometimes merely electrical frequencies may have that effect. The situation is most often quite typical: Patients become increasingly frustrated as they do not notice any improvement in their symptoms despite having eliminated their allergen most meticulously from their diet. They begin to doubt the effectiveness of the treatment's entire concept. On the contrary, inexplicably they experience tremendous waves of skin exacerbation and itching, etc.

Anyone who has not been informed of this possible occurrence does not even consider the possibility that allergens may also exert their influence via the physics code, which is purely intangible information. As this mechanism remains an entirely new concept, it confounds even the experts.

This is also the reason why elimination diets, regularly recommended for neurodermatitis patients, are rarely successful!

We have summarized the most important rules for the avoidance of the allergen in the case of hyperergy below (**cow's milk protein** and/or **wheat** are almost always the central allergens). Samples of the patient literature can be found in the appendix of this book.

Only if patients understand the term **avoidance of the codification** and are aware of all consequences of error, can they get through this phase without making mistakes. In those times of crisis, they need the particular help and support of their physician; else, they might doubt the overall concept and eventually give up.

Rules governing avoidance of the allergen in the case of hyperergy

- Any type of product containing allergens, in any form, must be **eliminated from the diet and the patient's home and environment.**
- Even the **handling** of the allergen—especially **heating it up**, **cooking** or **baking** with it—by another person releases the intangible information (the specific biophysical frequency pattern) and may subsequently cause severe

reactions. When opening the door of a microwave after warming milk in it, milk information infiltrates the room for several hours. People allergic to wheat, for example, must not enter a room in which wheat-containing dish es (e. g., pasta, dumplings) have been cooked or heated, cake has been-baked or wheat-bread toasted several hours before.

- For the same reasons, all **grocery stores**, **supermarkets**, **confectioners**, **bakeries**, etc. must be avoided. Additionally, every patient should be aware of the risk of going to a **restaurant**. If visiting other homes, make sure that no one has handled, cooked, or baked with the allergen the same day as the visit.
- In some cases, the hypersensitivity may be so severe that even **contact with people who have ingested foods containing the patient's allergen** may cause severe reactions. (In the case of hyperergic patients, we advise all members of the family living in the same home to simultaneously undergo the same strict avoidance of the allergen.)
- Mothers breastfeeding their babies need to be aware that their infants may not tolerate the **mother's milk** unless she herself eliminates milk from her own diet. Testing will quickly resolve this important question.
- Hyperergic phases are normally short-term, but may last for several weeks or months. They often occur directly after an allergy is de-masked, that is at the beginning of the phase of allergen avoidance. They may also occur in **times of increased stress**, **psychological tension**, **illness in its broadet sense**, etc.

Even if the patient does not currently experience a hyperergic phase, it remains **difficult to conscientiously avoid all diet errors**. If an error indicating contact with the allergen is suspected, the patients must eliminate all questionable food from their diet in order to find the mistake to prevent it from happening again. This is easier for people who can have their physicians test food samples.

It happens repeatedly that after a phase of distinct amelioration or complete clearing up of all skin conditions, there is a sudden or gradual exacerbation. If this occurs, any one of the following could be the cause:

- An **error** occurs **in the realm of intangible information** (e. g., the patient visits someone in whose home a cake was baked the same day).
- A **minimal amount of the allergen** is inadvertently ingested (e. g., the patient eats bread made with rising agents containing milk).
- An **intestinal mycosis** appears (particularly common after sugar binges).
- The error may be traced back to a simultaneously existing **acute allergy** (e. g., eating fruit candy in the case of an allergy to citrus fruit).

- A **new acute allergy** occurs (e. g., tomatoes, previously tolerated, now act as an allergen).
- The **general condition** of the patient deteriorates (e. g., stress at work or school, tension in the family, stress caused by an illness).

Let us emphasize again:

The most important factor that must be considered initially is the central allergen. Without a central allergen, there would be no neurodermatitis. Without completely avoiding it, there can be no healing!

Considering this important reminder, the **general diet** of a neurodermatitis patient is not that difficult. In any case, it is simpler than often portrayed. Due to the significance of neurodermatitis, its frequent occurrence, and the general uncertainty (medical circles included) as to its origin, numerous diet and therapy recommendations, often contradictory, abound.

Anyone who understands the therapy concept introduced in this book and has experienced it should not let literature, brochures, newspaper articles, well-meant advice by lay persons or physicians, specialists, even clinics cast doubts on it. (The concept proves itself in running its course. The reactions created by errors can be reproduced at any time.)

The following facts are fundamentally valid:

- Neurodermatitis patients may and should eat everything that is not prohibited in their cases. Only the foods that tested negative are forbidden. Otherwise, the diet should be as varied as possible.
- Simultaneous **acute allergies** need not pose a problem. The allergen (e. g., citrus fruits, strawberries, nuts) need not be avoided. Acute allergies can be eliminated as soon as they are diagnosed.
- One point that can never be emphasized enough is that the patients should be **extensively informed about their disease** and all related peculiarities.

Almost all patients who have been suffering from allergies for a long time possess a motley collection of "knowledge" about their problem. They receive information from a variety of sources: detailed explanations by specialists (physicians, allergologists, dermatologists, etc.), any type of specialist literature (books, brochures, newspaper articles, advertisements, etc) and hear-say by friends, family, neighbors, etc.

If patients are not successful in creating some order out of this chaos in some credible fashion—finding the correct correlations and dismissing in-

correct ones—they will find themselves more or less continuously influenced by suggestions coming from their environment.

Only if a clear concept convinces a patient, will he or she be willing and able to deal with all the inconveniences a new and unfamiliar therapy will entail.

Dramatic reactions may result if the patient were simply informed of the central allergy but not of the **significance of avoiding allergen exposure on the informational level** and the dangers of de-masking. We know several such cases and present one as an **example**:

Patient T. W., born in 1989
Since age two, the child had neurodermatitis including eczematous changes primarily on the face, neck, and back of the hands. In 1991, the family consulted with a colleague who had participated in one of our seminars, learning the principles of biophysical allergy diagnosis and therapy. He correctly diagnosed a **wheat neurodermatitis** and emphasized the avoidance of wheat. However, for some reason, he failed to explain the particularities of allergen exposure on the informational level.

The child had already undergone several unsuccessful treatment attempts, but the family now understood the correlation and was happy to finally be able to have found a path that promised success. Their disappointment was acute when, after a few days of strict avoidance of wheat, the skin condition worsened dramatically. The child experienced acute eczematous changes, never experienced previously. At that point, we saw the child for the first time (Fig. 12.53).

It turned out that the family correctly eliminated wheat from the child's diet as instructed. However, the intangible allergen information was not taken into account, since food containing wheat was still being handled, cooked, and baked in the kitchen.

Since our experience with the patient pictured in Figures 7.5 and 7.6, we know that allergen information released by heating food has a particularly strong effect on the sensitized organism. This case was aggravated by the immediate increase in sensitivity—the result of de-masking—which explains the severe worsening of the eczema.

The most important and effective action was to educate the family in detail and to augment the family's informational base. After correcting all errors, we were able to conduct biophysical allergy therapy to treat the wheat allergy. Figure 12.54 shows the child after conclusion of therapy, approximately 5 months after the first photo was taken (Fig. 12.53). If you think this is not the same child, look for the characteristic diastema.

Fig. 12.**53** Typical wheat neurodermatitis displaying an acute outbreak of eczema over the entire body. It occurred shortly after wheat had been eliminated from the child's diet. As the physician failed to explain the significance of avoiding allergen exposure on the informational level, food containing wheat (e. g., noodles) was cooked in the presence of the child. The acute exacerbation of the symptoms was due to the intangible allergen information released when heating the food.

Fig. 12.**54** Patient in Figure 12.**53** about 5 months later, after therapy had ended.

Avoiding exposure to the relevant allergen on the informational level is doubtlessly the most difficult task for any neurodermatitis patient. We find it effective to give patients extensive **literature** containing detailed information regarding their problem. This literature also lists reliable references such as health food stores, bakeries, grocery stores, etc. (Samples of the patient literature can be found in the appendix.)

It is important to warn patients not to follow unqualified, yet seemingly convincing advice and tips of uninformed sales persons, presenting themselves as experts. This applies particularly to health food stores, specialist departments of department stores, drugstores, etc., as well as all listed ingredients on packaging, advertisements, etc. There are few laws that are so regularly and brazenly broken as the food labeling laws!

Even experts are unaware of certain correlations important for people suffering from food allergies.

One typical example is the addition of wheat seed oil to most edible oils and oil-containing products (even if they clearly state "100% pure"). We do not know any bakers (and few food chemists) who know, off the top of their heads, that the informational aspect of cow's milk protein is present in most rising agents used in baking. This, however, is of great significance for someone allergic to cow's milk.

Another **example** from the practice:

Patient E. C., born in 1972
Since the first year of life, neurodermatitis with eczematous changes. Initially occurring in the flexures of the joints, later incidentally all over the

Fig. 12.**55** Localized cow's milk neurodermatitis appearing on the inside of both thighs.

Fig. 12.**56** Patient in Figure 12.**55** after strictly avoiding any contact with milk for several weeks. For the first time in many years, the skin is completely clear.

Fig. 12.**57** Severe reaction after a minimal, unintentional ingestion of the allergen. Patient in Figures 12.**56** and 12.**57** after eating a small piece of bread that a baker said positively did not contain any milk. However, the rising agent used to make the bread contained the informational aspect of milk.

body. Numerous therapy attempts using ointments as well as homeopathic remedies, laser acupuncture and nosodes using the patient's own blood, etc. did not lead to the desired success.

During puberty, all eczematous changes disappeared except for one particular site on the inside of both thighs (Fig. 12.**55**). The skin changes were strongly exudative and extremely uncomfortable for the patient, as all clothing would immediately adhere to the eczema. (To change cotton underwear, the patient had to sit in the bathtub for several minutes to soften the crustations.) We diagnosed cow's milk neurodermatitis. The patient strictly avoided milk and for the first time in many years the eczema healed (Fig. 12.**56**). A short while later, initially without reason, the patient experienced a severe worsening (Fig. 12.**57**). It turned out that the patient had eaten a small piece of bread that the baker had declared to be positively free of milk. However, a test revealed that it contained one of the previously mentioned rising agents. The error was corrected and the patient has not experienced any further manifestations of eczema. This case demonstrates the lack of awareness on the part of the baker. The next example illustrates the dangerous effects **"know-it-all"** experts may have:

Patient S. T., born in 1990

At 2 months, neurodermatitis, specifically in the facial region and in the flexures of the extremities. We diagnosed cow's milk neurodermatitis. After

Fig. 12.**58** Severe reaction to cow's milk. Neurodermatitis worsened following an iatrogenic error. While in the phase of avoiding exposure to the allergen, the child was admitted to a pediatric clinic due to intercurrent pneumonia. The acute exacerbation was caused by the improper diet the child received during his stay in the hospital. This diet exposed the child to milk.

eliminating cow's milk from the diet, the eczematous changes improved quickly and significantly.

At 14 months, the child fell ill with pneumonia and the family physician admitted the patient to the closest university hospital.

The mother's earnest pleading for a diet free from cow's milk was dismissed with the words: "*We will conduct relevant tests to determine if the child is indeed allergic to cow's milk.*" Meanwhile, the child received a diet containing limited amounts of cow's milk. As the child continued to be exposed to the allergen, severe exacerbation of the skin condition occurred within a few hours of ingestion (Fig. 12.**58**). Subsequently, the mother decided to take the child home at her own risk.

Both examples (we know of numerous other similar cases) are meant to demonstrate how dependent patients, who suffer from central allergies, are on accurate information. The physicians treating these patients are, in a way, their last resort. In case of doubt, they need to support the patients or conduct tests, thereby distinguishing permitted and forbidden foods. Anyone who is proficient in identification testing can have patients mail in questionable food samples (preferably packaged in aluminum foil and labeled). Patients can then call and get the results by phone. (Identification testing is a variant of the allergen resonance test and can be learned in a weekend seminar.)

The patients, the patients' families and entire environment must also be educated with regard to the strict avoidance of the allergen. Everyone must contribute for the goal to be attained. Overly affectionate aunts and grandmothers, etc. making stereotypical remarks such as "*this little piece won't hurt you*," seducing the child to eat one of the forbidden sweets are dangerous. Just as dangerous for the adult are thoughtless or uninformed friends or coworkers who often show astonishing persistence in tempting one to commit an error.

Another example to illustrate this point:

Patient E. F., born in 1989

Neurodermatitis since the first weeks of life; located specifically in the flexures of the extremities, on the neck and the stomach. We diagnosed cow's milk neurodermatitis based on the typical clinical symptomatology. The allergen resonance test indicated an isolated cow's milk protein allergy.

We instructed the family to avoid all exposure to cow's milk. Subsequently, the child received soymilk bottles and baby food completely free of cow's milk. The skin condition improved rapidly until a visit to the grandmother. Certainly, the grandmother did not want to harm her grandchild when she fed him a small cookie before the mother was able to intervene. By any stretch of the imagination, she could not imagine that such a small amount of cow's milk, which might be contained in the piece of cookie, should cause a reaction in the child. The same evening, the child experienced an acute, severely pruritic exanthema in the face and extremities. Interestingly, it displayed completely different characteristics than the previous manifestations of the neurodermatitis that were in the process of healing. The reaction, the acute urticarial exanthema, on the face and on the child's right arm can be seen in Figure 12.59. Some residual patches of the original neurodermatitis are still visible on the stomach.

Such observations are common; they display the change an organism undergoes when starting the phase of allergen avoidance. Constant allergen intake masks an allergy. De-masking it temporarily leads to increased sensitivity. An error committed in this phase may cause a critically acute reaction, even a true anaphylactic reaction.

Overall, the phase during which any contact with the allergen must be strictly avoided is difficult for patients and their families. It is unavoidable in severe, long-term neurodermatitis cases.

In the meantime, we have had several years of experience with this type of neurodermatitis treatment. Our observations have shown that it is usually possible to motivate the patients accordingly. Of course, the large number of completely healed patients contributes a great deal. Patients often come to us through hearsay. At the least, chatting with other patients in

Fig. 12.**59** Acute urticarial exanthema following a miniscule dietary error in the case of cow's milk neurodermatitis. The grandmother had fed the child a tiny piece of home-baked cookie. The face and the right arm clearly show the urticarial characteristic of the reaction after exposure to the allergen. The residual neurodermatitis is visible on the stomach.

our waiting room, exchanging experiences, increases the motivation to undergo this obviously successful therapy. After all, these patients and their families have been suffering for a long time, having experienced many frustrating therapy attempts. If the disease can be truly cured, people are quite willing to take on a difficult task.

Biophysical Allergy Therapy

For patients suffering from severe neurodermatitis, the successful treatment of their chronic allergy is the highlight, so to speak, and the reward for the effort of avoiding the allergen. Now the body seems to be adjusted to and tolerates physical therapy without experiencing any adverse reactions.

Until 1992, we conducted eight treatments per allergy therapy using the relevant allergen and program 999. During this phase of several weeks, any exposure to the allergen had to be strictly avoided. **The new methodologies**

where allergen avoidance is no longer necessary simplified the situation considerably.

As soon as the effect of avoiding the allergen is visible (symptoms improve considerably and/or disappear), allergy therapy can be conducted. At this point, it usually no longer causes a negative reaction. We routinely apply three therapies using the BICOM settings of program 998 and/or 977. For the duration of the therapy, the allergen is in the input beaker. The treatments are spread across several days. The timeframes between the individual treatments are unimportant. Only if the patient lives far away, do we limit ourselves to one or two appointments.

After conclusion of the therapy series, we conduct a control test that usually turns out negative. This means the patient no longer has to avoid contact with the allergen. It can then be tolerated without any reaction!

The further course of the dermatosis depends on several things: To what extent, for example, are the preferred sites on the skin lichenified or possibly atrophied from the use of corticoid topicals? Is the usually concurrent mycosis already under control at this stage?

In less severe cases, especially in children, the eczematous changes may be completely healed at this point. The patient is rid of his/her neurodermatitis.

Patients who have had severe skin conditions for an extended period of time must always undergo a localized follow-up treatment specifically addressing the fungal problem.

Fungal Therapy

Residual mycoses, which are surviving fungal infections appearing in the sites of the healed eczematous changes of neurodermatitis (see p. 195), may be very persistent and will simulate a continuation of the neurodermatitis. For several years, treating these chronic fungal foci has been quite difficult for us. After many frustrating attempts using the most varied antimycotic ointments, we discovered **ozone** as an effective agent to counter the fungi.

We now routinely treat all skin mycosis with **ozonized olive oil** (Dr. J. Hänsler Inc., Iffezheim, Germany: www.ozonosan.de). The ointment is applied on the skin once or twice a day. Even though the strong smell of ozone is unpleasant, most patients tolerate it. If the eczematous sites are on the extremities (hands, feet, elbows, back of knees), the application of local **ozonification** is quite successful (Fig. 12.60). Consult pertinent literature for technical details regarding this method (Rilling and Viebahn 1990). Ozone has also proven effective to treat **intestinal mycosis**. If we find candida in the stool, we routinely initiate **rectal ozone insufflation**. This consists of a total of five treatments on different days. The patient is

Fig. 12.60 Ozone gas treatment for residual mycoses on the hands.

administered a mixture of ozone and oxygen via a catheter into the rectum. The quantity of the mixture depends on his/her age. (See the abovementioned literature for details.) The procedure itself is easy and entails nothing more than proper operation of the ozone device. Young children and infants tolerate the treatment without any problems.

The **elimination of mycotoxins via the BICOM device** (program 998) **is crucial for every mycosis therapy.** To do this, a sample of the patient's stool must be kept from the beginning (cotton swab is sufficient). It is certain to contain the exact type of fungi specific to the patient. Every time we conduct an elimination treatment, this cotton swab and the candida albicans test ampoule are placed into the input beaker of the therapy device. If ozone is not available or cannot be used, for whatever reasons, chemical antimycotics are unavoidable. Because of its documented effectiveness for candida, we use oral **nystatin** (juice or pills) in these cases. The dosage must be adequate for the age, but not less than necessary; the length of treatment should be at least 2, preferably 3 weeks.

For several weeks after discontinuing antimycotics or the conclusion of the rectal ozone therapy, patients routinely receive preparations to **build up their intestinal flora** (e. g., Pro-Biotics Acidophilus (1 capsule daily).

During the antimycotic therapy and afterwards the **patient must adhere to a strict sugar-free diet.**

To live, all fungi need an organic source of carbon, as they are not able to manufacture carbohydrates from carbon dioxide and hydrogen. The most important and most accessible source for organic carbon is all simple types of sugar such as dextrose, fructose, cane and beet sugar, malt sugar, etc.

The more sugar available to fungi, the better they grow. In one night, they can double their numbers several times if they have a variety of sources of usable carbohydrates at their disposal as are found in any type of sweets, chocolate, pastry dishes, honey, sweet beverages, sweet fruit, compotes, jams, etc.

In addition to avoiding any food containing sugar, it is important to mechanically eliminate yeast foci in the small and large intestine. This is achieved by eating plenty of roughage whereby vegetables and salads may be eaten, cut up into very small pieces. Plant fibers are particularly effective in cleansing the system when ingested several times daily.

In addition to proper diet, basic hygienic steps need to be considered. Any efforts to eliminate the fungi from the intestines using an anti-fungal diet and medication are futile, if carious teeth, tartar, periodontal pockets, and dental prostheses act as fungi reservoirs in the **oral cavity.** At the very least, before beginning any antimycotic therapy, the toothbrush should be changed.

The guidelines presented here are based on the works by Rieth (1990). The duration of the dietary measures depends on the severity of the fungal infection. Usually, patients must strictly adhere to the diet for at least 2 weeks, at any rate for the duration of the administration of antimycotic medicine. Following antimycotic therapy, they must maintain a diet with moderate sugar intake for several weeks.

We also supply patients with information regarding a sugar-free, anti-fungal diet (see appendix). Even after all skin manifestations have healed, patients have to be prepared to experience recurrences of mycoses for several months or years. Mycoses foci on the skin, considered already healed, may frequently flare up again when excessive amounts of sugar are consumed, for example during vacation time or festivities. Relapses of intestinal mycoses may easily occur after oral antibiotics therapy.

Whenever patients whose neurodermatitis healed previously experience renewed problems with their skin or suspect a potential relapse, their **stool must be checked for candida**. It is possible for intestinal candidosis to trigger a destabilization of the skin. A developing candida allergy must always

be taken into the consideration of a subsequent imminent or already existing candida neurodermatitis (see p. 200). Before dismissing our patients from our practice and observation, we instruct them in detail about the significance of mycoses in relation to skin changes. They receive the strict directive to immediately send a stool sample to be checked for candida any time the eczema flares up again or itching rashes, etc. appear.

Topical Therapy of Neurodermatitis

Treating neurodermatitis successfully via the skin is futile. Any attempts to that effect operate under the incorrect assumption of the disease. Topical therapy only serves as **skin care**. As previously elucidated, the actual treatment takes place, exclusively, via the internal mechanisms.

Skin care usually necessitates neutral, lightly greasy ointments (e. g., a mixture of triamcinolone acetonide ointment USP [**oil-in-water emulsion**] and triamcinolone acetonide cream USP [**water-in-oil emulsion**]). Bath oils containing lipids (e. g., Alpha Keri) have proven effective. Some patients have had good experiences with sea salts (Frontier Natural Products).

Ointments containing corticoids should be used only as a stop-gap measure. Their short-term application is acceptable if the itching becomes unbearable and in the case of acute exacerbation as may occur due to unintended exposure to the allergen, particularly at the beginning of the treatment. Anyone aspiring to do completely without cortisone ointments merely illustrates that he/she has not entirely understood the therapy concept. A short-term suppression of an occasional excessive reaction will do no harm. On the contrary, it may spare the patient many hours of suffering!

Consistent treatment of a severe neurodermatitis doubtless requires patience and persistence from all participants. On the other hand, the experience of truly healing such a painful and stressful disease is one of the highlights in the career of every physician.

The following excerpt illustrates a family's sentiments with regard to this situation. A mother sent us a letter after both of her children had recovered completely from severe, long-term neurodermatitis:

"It still seems like a miracle to me that after these many years of terrible scratching day and night, my children are cured. They no longer have rashes; they can live normally and eat whatever they want. I am not exaggerating when I say that you have helped our entire family. All these years of countless sleepless nights (the itching was worse at night), worrying about my children's future affected my own health and nerves quite negatively as well. All this is now a thing of the past, forever I hope..."

The letter is dated August 1990. The children have been healthy for many years, free from any skin irritations.

13 Ulcerative Colitis and Crohn's Disease

Ulcerative colitis and granulomatous enterocolitis (Crohn's disease) are considered chronic inflammatory conditions of unknown origin of the gastrointestinal tract. Their clinical course is characterized by periods of relapses and spontaneous remissions. They primarily affect adolescents and young adults. It seems that in the future the age group will expand in both directions.

The symptoms, which include diarrhea containing mucosal secretions and blood and malabsorption, can vary drastically. Primarily diagnosed radiologically and/or endoscopic histologically, the etiology remains unknown.

The single point that the experts agree upon is that genetic predisposition plays a significant role. Similarly, as in the case of atopic diseases, there is a familial incidence. In cases where both parents have been affected, their children run a distinctly higher risk of illness.

Regardless of the fact that some extraintestinal manifestations of the disease might have been implicating allergic mechanisms, they have never been seriously discussed.

Quite frequently, for example, epidermal alterations such as **erythema nodosum** precede the intestinal symptoms. Naturally, similar epidermal eruptions come to mind that are occasionally observed at the onset of cow's milk neurodermatitis. Interesting in correlation to these findings is the study by US American scientists who found higher concentrations of serum antibodies to cow's milk protein in 80 children suffering from Crohn's disease and ulcerative colitis.

The idea of a chronic food allergy, as defined in the first section of the book, may seem quite obvious. Yet, it can only be substantiated with additional patient data.

We have not had enough experience with this disease in our pediatric practice. However, we know colleagues who have made interesting observations in this area.

In the case of colitis and Crohn's disease, R. Oesterle, the German gastroenterologist and proficient bioresonance therapist may be the most experienced in the biophysical diagnosis and therapy methodologies. Since 1988, using biophysical methodologies, he has examined all of his patients affected by chronic inflammatory intestinal diseases for the presence of a chronic food allergy. He found that out of eleven patients with ulcerative colitis, nine had an allergy to cow's milk protein and two were allergic to wheat. In

four out of six Crohn's disease patients, the central allergen turned out to be cow's milk; for the other two, it was wheat.

This data is not extensive enough to be considered definitive. Yet, it is significantly interesting and substantial enough to warrant further investigation.

Here again, the crucial argument is the success of the therapy! In the past, experts concurred that this disease was incurable. The fact that there is now no question as to the ability to cure it in the long-term should be a signal specifically for those experts to take a closer look at the methods employed.

Applying our method—strict avoidance of the allergen and subsequent therapy with the inverted oscillation of the allergen—Dr. Oesterle was able to attain true curative results that could be verified by colonoscopic and histologic controls.

Another interesting observation relating to this is that occasional relapses were always traced back to intestinal candida mycosis. After appropriate fungal treatments the symptoms disappeared again.

We do not mind admitting that our experiences in terms of chronic inflammatory intestinal diseases are not extensive. Yet, we have noticed distinct similarities to neurodermatitis. Therefore, we hope that the application of biophysical methodologies also brings about a change in this arena, as is already seen quite clearly in the case of neurodermatitis.

14 Celiac Disease

Celiac disease is the only chronic food allergy with a pathomechanism that allopathic medicine is clear about and generally accepts.

It is defined as the long-term tendency to react to ingested gliadin, which damages the mucosa of the small intestine.

Gliadin is an element of gluten contained in specific types of grain (wheat, rye, barley, oats). It is a combination of various proteins. Digestion does not negate its antigenic characteristics.

Susceptibility peaks in infants and toddlers, then decreases. It may increase again after the age of twenty.

The symptoms—**stunted growth, frequent and bulky stools, and bloated abdomen**—are most pronounced in small children. Later in life, celiac disease should be suspected if the growth and weight curve inexplicably flattens out. For allopathic diagnosis, besides the proof of gliadin antibody presence (somewhat problematic), **a biopsy of the small intestine is required**.

Significantly flattened villi are considered proof of the presence of celiac disease.

Disciplined patients who have learned to properly eliminate gliadin from their diet are usually symptom-free. Plenty of information and help is available about a gliadin-free diet, which makes dealing with the disease easier.

The interminable aspect particularly stresses people affected by the disease. That is to say, they have to adhere to dietary restrictions for the rest of their lives.

Biophysical medicine can be of help here. However, difficulties arise when judging the success of the therapy and the subsequent course of the disease after conclusion of the therapy.

When patients come to us, they usually have been previously diagnosed and have adhered to a strict diet for an extended period of time. Positive biophysical allergy testing to gliadin confirms the diagnosis. The treatment, comprising placing gliadin in the input beaker of the BICOM device (program 998, as described previously), rarely causes serious difficulties. Following a properly conducted therapy, a biophysical allergy test customarily tests negative to gliadin.

Patients may now include gliadin in their diet again and resume eating a normal diet. However, with the exception of a possible biopsy and strict monitoring of the patient's progress, we have no means with which to verify and control the therapy success, which is, ideally, complete gliadin tolerance. The actual difficulty in the assessment is the time it takes for the symptoms to manifest.

Several weeks or months may pass before negative effects of gliadin stress are visible. Meanwhile, the intestinal mucosa may have again changed, suffering further damage. When used to check the course of celiac disease, rarely have biophysical tests proven reliable. We know of two cases that demonstrated that the symptoms of celiac disease reappeared after several weeks of gliadin exposure, even though gliadin tests were consistently negative. In one of those cases, after several months, a biopsy of the small intestine revealed a renewed villous atrophy.

After every concluded biophysical therapy of celiac patients, we face the same dilemma: In the case of therapy failure (in our experience this is rare, but it does occur) a patient would be ill advised to discontinue his/her dietary restrictions, as they would still be deemed necessary. On the other hand, strict dietary restrictions are unnecessary in the case of a successful therapy.

At this time, there is no solution. Patients must be aware of this issue and decide for themselves how to proceed.

If someone consciously chooses to eat a normal diet containing gliadin (provocation), the general condition of health has to be monitored as well as the stool consistency in the following months.

As regards children, the growth and weight curve must also be monitored. In case of doubt, after several months, a biopsy of the small intestine must be conducted to determine whether the patient is cured or will have to continue to eat a gliadin-free diet for the rest of his/her life.

15 Allergies to Insect Venom

Allergic reactions to insect venom are of particular importance. Acute and immediate life-threatening anaphylactic shock, the worst kind of allergic reaction, is especially common in these types of allergy. The lives of hundreds of thousands of people are affected each summer. Whether they like it or not, they have to undergo long-term therapies that may be potentially harmful in order to partially eliminate the danger of this threatening allergy.

Sensitized individuals react rather quickly. Two stings within months or years are sufficient for anyone genetically predisposed to manifest the allergy. Any further sting may cause severe symptoms.

Symptomatology

When stung by a bee or wasp, a localized, painful itching or burning sensation is normal. If the sting occurred at a more vulnerable site (tongue, mouth, throat) or in the case of a large number of stings at one time, even non-sensitive individuals may be endangered.

Levels of sensitization according to Mueller:

- Level 0: Increased local reaction.
- Level I: Generalized skin rashes, itching, nausea.
- Level II: Edema, vomiting, diarrhea, dizziness.
- Level III: Difficulty breathing, weakness, dazed.
- Level IV: Severe anaphylactic shock accompanied by hypotonia, unconsciousness, cessation of breathing, and circulatory collapse.

Diagnosis

Anamnesis is the most common method of diagnosing allergies to insect venom. Patients are often quite expressive in recounting their symptoms. Detailed questioning quickly reveals the severity and the level of reaction (see the previously mentioned gradation by Mueller).

Diagnosing the specific type of insect, using allopathic methodologies, often presents difficulties in practice, even though **bees** and various **types of wasps** (specifically the common wasp, vespula vulgaris) are the only two

possibilities. Often, the patients themselves are not certain which type of insect is dangerous to them. At the least, they have a hard time distinguishing wasps from bees. Common skin tests are quite dangerous for highly sensitized patients. Due to the threat of severe allergic reactions, tests must be conducted with extreme care and a very low allergen concentration. Emergency measures must be at the ready.

In this case, in-vitro testing to gain evidence of specific IgE antibodies is not very reliable (e. g., the most common radioallergosorbent test worldwide = RAST). A study of children in Bavaria, by a team from the university clinic in Munich, found that the blood of more than 40% of the individuals tested contained IgE antibodies to bee venom. None of these children had ever had any reaction to a sting (Przybilla 1992).

Uncertainty remains despite clear-cut anamnesis (patients know that they react to insect stings and what type of reaction occurs) and simple questioning (bees, wasps, or possibly both). As any subsequent therapy is dependent upon an exact diagnosis, this uncertainty may have important consequences.

Hyposensitization treatment, the only effective method commonly recognized, presents considerable stress and danger to the patient. Therefore, it requires a strong case for its indication.

A point scale helps determine this situation (Urbanek): The level of severity of the patient's allergic reaction is established, the swelling of the skin and the amount of specific IgE antibodies in the serum (RAST level) are assessed. All are evaluated according to a point scale. If the patient achieves a total score of more than 5 points, hyposensitization is indicated. Various experts of allergology repeatedly question the efficacy of this procedure, yet to date no other solution is evident. Anyone who is proficient in the biophysical diagnosis and therapy methods has other, simpler options: The relevant allergen can be determined within several seconds without placing the patient in the least danger. Sufficient information has been obtained to immediately initiate the appropriate biophysical therapy. This therapy is not stressful to patients, nor does it pose any danger to them.

Therapy

Contrary to the hyposensitization treatment, biophysical therapy does not take into consideration the patients' sensitization and the severity of their symptoms.

The technique applied is the same as for all other allergies: deconstruction of the allergy imprint using the inverted frequency of the allergen.

Meanwhile, the method we and most of our colleagues used previously for this, BICOM program 999, is now outdated.

Program 998 (amplification of allergen information) has proven effective for this indication. Additionally, on a different day, we adminster a treatment in frequency range 24 kHz (**BICOM program 978**).

We routinely apply three therapies on subsequent days (or they may be further apart). Proceeding in this way, negative reactions have yet to be observed.

Allergy testing is repeated after the final treatment, usually producing a negative result. Note that initially all immunological testing commonly results in a positive test. This does not mean that biophysical therapy failed. (See Part I, p. 108)

Of course, the success of the therapy can ultimately be proven only when the relevant insect stings the individual again. Allopathic allergology evaluates the effect of hyposensitization therapy by intentionally provoking a sting from the relevant insect (whilst being prepared for an emergency). We have never been willing to do this. However, we do not release patients from our care without advising them quite urgently to temporarily continue to carry their antidotes (i. e. emergency kit) with them until the next sting brings a negative result.

This precaution covers the legal aspect that may become an issue if patients discarded their safety measures upon their physician's advice and then came to harm.

Nervously awaiting the next sting after conclusion of the therapy may lead to amusing situations as **two examples** from our practice illustrate:

Applying our usual methods, we treated a 6-year-old boy who had been allergic to bees for two years. He had been in the hospital several times for systemic reactions, up to level III. After the third therapy, mother and child left our practice only to return terribly agitated several minutes later. A bee had become entangled in the collar of the child's shirt and stung him. Immediately commotion overtook the entire waiting room. Patients and their families were watching the child with fearful anticipation, expecting something dramatic to happen any minute. We looked the child over and were reassured. While the boy was allowed to play in the waiting room, the mother was instructed to immediately report any suspected reaction. An hour later, both were able to go home without worry. Since then, the child has been stung several times by bees without developing anything but the normal reaction expected from a bee sting.

Another example, somewhat anecdotal in its drama, is of an 8-year-old boy, whom we treated for wasp sting allergy. Having suffered several anaphylactic reactions of level IV prior to our therapy, his family was sufficiently familiar with the necessary emergency procedures. A few weeks after

conclusion of the treatment, a wasp stung the boy in an outdoor swimming pool. He and his caretaker immediately sounded the alarm. Everybody wanted to help. The lifeguard called the emergency air rescue and a helicopter appeared within several minutes. Its poolside landing was sensational, enjoyed by young and old. The one who most enjoyed it was the hero of the story, our patient, who had a great time on his way to the intensive care station of the hospital where he was sent home after a short examination. He, too, no longer developed any systemic reactions to wasp stings.

16 Urticaria

Urticarial exanthema is a commonly known allergic skin reaction. However, overall a relatively small percentage of urticaria cases are due to allergies.

Biophysical methodologies can treat the allergy leading to urticaria, yet they cannot heal the symptom itself. Forms of urticarial exanthema not caused by allergies frequently do not distinguish themselves phenomenologically from other forms stemming from allergies. In other words, the pathology is often the same, irrespective of whether the urticaria is initiated by an allergy. However, the different types are subject to different laws and require different therapies.

Symptoms of Urticaria

A characteristic symptom is the sudden appearance of wheals (urtica). Wheals are formed by blood plasma leaking out of small blood vessels in the skin. They quickly change form and appearance and are strongly pruritic. A single wheal is usually raised with erythematous borders and central blanching.

A particular form of urticaria is the angioneurotic edema (primarily known as Quincke's edema). Triggered by the same mechanisms as urticaria, angioneurotic edema involves the vessels in the layers of the skin below the dermis, while urticaria is localized superficial to the dermis. The former leads to larger edematous tissue swelling.

Allergic Forms of Urticaria

The allergic forms of urticaria rarely present difficulties when we apply biophysical methods. Contrary to allopathic medicine, which already encounters great difficulties in diagnosing the suspected allergen, our methods enable us to check the allergenicity of all substances the patient suspects within a few minutes, in one session.

If the suspected allergen is confirmed, we can immediately begin therapy thus preventing a recurrence of urticaria, caused by the same substance, in the future. Even though bioresonance therapy influences the urticarial skin

reaction only indirectly, it disappears by itself within a few hours after the elimination of the allergic mechanism.

Theoretically, all substances that cause any kind of allergic reaction can trigger allergic urticaria. Experience has shown however that some substances cause urticaria frequently, others less so. Among the former are many pharmaceuticals, lead by penicillins; among foods, fish protein, cow's milk protein, chicken egg protein, and strawberries; among food additives, various azo dyes (e. g., tartrazine) and certain preservatives (e. g., PHB ester). Last, but not least, let us not forget mold fungi, intestinal fungi (candida), and parasites (intestinal helminths).

Urticarial reactions to cow's milk protein are interesting. They are commonly observed in young infants that are on a cow's milk-free diet (i. e. breastfed) and rarely receive small amounts of food containing cow's milk (see Fig. 12.59, p. 218).

Occasionally, acute urticaria is the initial symptom of a gradually developing cow's milk neurodermatitis. In other cases, although initially undistinguishable, it is restricted to episodic urticarial reactions. These patients usually tolerate any amount of cow's milk without any problems.

Non-allergic Forms of Urticaria

Even though non-allergic forms of urticaria are also based on a histamine mechanism, immunological processes do not cause it. For example, the **direct influence of contact noxa** on the mast cells may release histamines. Commonly known are the painful reactions to plant substances (e. g., stinging nettle) or contact venom of animal origin (e. g., the hairs of particular caterpillars and the venom of jellyfish or other marine animals).

Basically, the most important group of non-allergic forms of urticaria is caused by **external physical circumstances.** Various physical stimuli—**pressure, warmth, cold, light**—may cause the degranulation of mast cells and release of mediators, and thus lead to typical skin reactions in some people. Their external appearance cannot be distinguished from allergic reactions.

Usually, sensitivity to physical stimuli is temporary. In many cases, we find an additional **trigger**, whose presence or effectiveness seems necessary to induce the reaction. In our experience, latent allergic stress is often (but not exclusively) a contributing factor.

Figure 16.1 illustrates a typical **example**:

Patient N. M., born in 1988

The child was brought to us because itchy wheals were appearing more and more frequently on the skin exposed to localized pressure. The family was not aware of any allergies, but reported that the child repeatedly used to have mild eczema in the flexures of the extremities.

Examination revealed the typical symptomatology of **urticaria factitia** (Fig. 16.1). After a few minutes, firm stroking of the skin with a wooden spatula lead to a response characterized by a pruritic red line, flare, and wheal reaction, lasting several hours. Allergy testing resulted in a mild allergy to cow's milk protein. Otherwise, it was negative. We eliminated the cow's milk allergy with the usual methods, resulting in immediate and long-term disappearance of the pressure urticaria.

This case turned out to be a latent (asymptomatic) cow's milk allergy that seems to have been the trigger for a physical urticaria to appear.

A **similar case**, yet with a different trigger mechanism, is pictured in Figure 16.2.

Patient P. B., born 1982

For several years, the child had been known to have allergies to various types of foods and animal epithelia. As is common in allopathic medicine, the allergies were treated with antihistamines, etc., prior to the visit to our practice. Independent of the known allergies (e. g., rash in response to peaches), the child had experienced pruritic, urticarial eruptions on the entire body for several months. These eruptions were clearly induced by physical exercise and resultant sweating. Figure 16.2 pictures the skin condition after use of an ergometer to provoke sweating.

Initially, the skin remained normal in appearance. Shortly after beginning the exercise on the ergometer (clothed, in a warm room), the urticarial rash, pictured, appeared. It was strongly pruritic, polymorphous, disappearing by itself after several hours.

We know this type of urticaria as **cholinergic urticaria**; allergic mechanisms are only indirectly involved.

Additionally in this case, allergies (latent at that point) played an obvious trigger role. The cholinergic urticaria disappeared immediately after elimination of the various acute allergies. There has been no recurrence.

A **third example** from practice is meant to demonstrate that other allergic mechanisms may also trigger cholinergic urticaria. A 24-year-old student experienced sweat urticaria in the hectic days immediately prior to difficult exams. Breaking out in a sweat during the actual exam was the most difficult to endure. Porcelain-colored wheals formed over his entire body. He could barely stand the itching.

Fig. 16.1 Urticaria factitia caused by stroking the skin with a spatula. A latent (asymptomatic) cow's milk allergy is the trigger.

Fig. 16.2 Cholinergic urticaria induced by sweating and physical exercise. Latent allergies are suggested as the trigger. (After eliminating all allergies, the tendency to display cholinergic urticaria disappears completely.)

Nevertheless, he managed to pass his exams and graduated as a doctor of medicine. Since then, no longer under pressure to pass exams, he has never had another urticarial reaction of any kind.

Besides psychological and latent factors, **intestinal mycoses** and **helminths** may act as triggers for urticarial reactions. For any urticaria, no matter if it is acute, recurring, or chronic, we routinely test the patient's stool for candida and worm eggs (specifically *Ascaris* species). This is frequently the key to an effective treatment of an otherwise, at the very least, unpleasant situation, which is often hard to influence. (Corticoids are ineffective pharmaceuticals for physical and cholinergic urticaria. The most likely substances promising a certain mitigating effect are antihistamines, which are superficially effective.)

Photoallergy

Included in the group of hypersensitivities to physical stimuli are the various types of photoallergies. Distinguishing them from phototoxic reactions is sometimes quite difficult.

Phototoxic reactions are based on the interaction of UV rays, a sensitizing substance, and the skin. Chemical substances may act as photosensitizing agents (e. g., various medications) which, when ingested, effect a systemic photosensitivity. Localized contact with photosensitizing substances causes a phototoxic reaction. It develops on the site where this substance comes into contact with the skin subsequent to exposure to sufficient amounts of light. Meadow grass dermatitis (dermatitis pratensis) is a typical example. It is marked by bizarre patterns of frequently bullous epidermic alterations occurring on the sites after intensive contact with plants.

A true **solar urticaria** (urticaria solaris) with wheals on the skin areas exposed to the sun is a markedly rare clinical occurrence. Even though we have not yet come across a case like that in our practice, we think it possible that, here as well, various trigger mechanisms may exert their influence. A familiar example of a photoallergic reaction obviously caused by various factors is the polymorphous photodermatosis, referred to as **sun allergy**.

It is characterized by pruritic, papulous, or vesiculous, occasionally lichenified skin rashes localized to the exposed areas of the body. In terms of localization and efflorescence, the same changes usually take place in the individual patient. Annual recurrences rarely change their appearance from one year to the next. However, their manifestations vary considerably from one patient to another, hence the name polymorphous photodermatosis. Although its origin is unknown, various mechanisms may interact with each other producing the resulting symptomatology. It is most frequently experienced during the first days by the ocean when the pale skin is exposed to intense ultra violet rays. At the same time, the patient is additionally exposed to unfamiliar factors such as warmth, climate, food, seawater, and sunscreen.

Treatment of the already erupted dermatosis can usually address only the symptoms. Consistent protection from the sun is paramount. Strengthening and pre-tanning of the skin is recommended as a means of prevention. In any case, the time during which light intensity is low and the patient is symptom-free should be used to treat and eliminate all other allergic and toxic stress. Here, too, bioresonance therapy in all its varieties has proven extraordinarily effective.

Epilogue

This book was written for several reasons.

The most important probably stems from a missionary attitude: That is, to share the experiences gained in our practice with other colleagues. These are experiences we, ourselves, consider unusual which enabled us to help many patients who could not have been helped otherwise.

Further, it is an attempt to give the reader an insight into the fascinating realm of biophysical medicine. Many things seem incomprehensible, incredible, and even unreal in this field. Yet, we have been able to operate successfully in it. There are almost no other therapy methodologies that are so difficult to comprehend, while at the same time so simply applied in practice, as the biophysical allergy therapy. Few therapies can demonstrate such astonishing results.

Another goal of this book is to provide interested physicians and therapists with practical instructions.

Interested or affected patients, that is to say lay people, may read this book. The use of medical terminology in the book may result in a lack of understanding, but we hope nevertheless that it helps the patients to form their own opinions and thus enable them to critically question any suspect, intrinsic medical scientific view of the day in the future.

Even though biophysical medicine is still in its infancy, the pressure patients exert on physicians, health insurance companies, and educational institutions is already significant. There are too many allergy patients who have undergone extensive, stressful (and for insurers, costly) diagnoses and treatment methodologies without experiencing significant improvement or relief.

If these patients find a simple method that irrefutably cures them in a short period of time, without adding additional stress, it is quite understandable that they will demand official recognition (and reimbursement) of that treatment method with greater frequency and ardor.

In this context, we repeat the previously quoted citation by Victor Hugo: *"Nothing is more potent than an idea whose time has come!"*

Doubtlessly, the time has come to include another dimension and rethink our previous ideas about the world, life, medical science, and all phenomena we encounter daily. This applies to all of us, whether physician, patient, or simply the thoughtful individual.

As much as we would like the biophysical aspect of our world, specifically medicine, to leave its mark in the reader's awareness, we do not want to create and present an a**lternative** to classical, allopathic, scientific medicine.

The medicine of the future does not need polarity between an "official" and "alternative" medicine. It does not need multiple directions of thought in conflict with one another. Rather, what is essential is a synthesis of a revolutionary, significantly more comprehensive overall picture.

It is questionable if this ideal will ever be realized without the established medical community learning to be more factual and rational towards new methodologies.

If a professor of medicine publicly calls bioresonance therapists *"pied pipers of the 20th century,"* or if in a widespread medical publication we find an allergology expert opining that bioresonance therapy cures *"allergies that do not exist"* with the only intention of *"making a fast buck,"* these statements speak volumes about how uninformed the "experts" are, maybe a little envious also; this is certainly not factually-based criticism.

It may be that the current methodologies allopathic medicine has at its disposal are insufficient for some allergies that we are able to treat and cure. It may also be that a colleague firmly rooted in the ideology of allopathic medicine cannot conceive of biophysical interrelations. It is certainly not an attitude that demonstrates a willingness to communicate. Rather they are content to accuse bioresonance therapy of fraud, the "pied piper effect," and exploitation, based on the motto, *"something that cannot be, must not be."*

As long as specialists in the field of allergies arrogantly defend these kinds of archaic and outdated ideas without risking a peek beyond their own imagination, we will likely have to wait for the essential contact to be established.

Yet, we do not want to end this book with negative, resigning statements when we are hoping to make a positive contribution to the convergence of varied points of view.

Young people are called upon, who are increasingly growing up with an awareness of interrelatedness. They are learning to comprehend the idea that the world controls itself and is a complex system regulated by higher-level mechanisms.

We have faith in young minds to find the right path into the future by choosing between the historical ideology, discarding outdated ideas, and being open to new ideas.

Bioresonance therapy is certain to play a vital role.

Appendix: Information for Patients

Anyone who is able to accurately diagnose and effectively treat allergies long-term will soon be inundated with patients. Consequently, this leaves little time for the imperative, explanatory **consultation of the patient**.

We have found it beneficial in our practice to hand patients or parents flyers containing extensive information vital to the process, which they can read repeatedly.

The consultation still has to take place, but with the flyers available as reference, it can be abbreviated.

1 Cow's Milk Allergy

Cow's milk protein is virtually the first foreign protein the body of any human being in our culture is confronted with. After a child has been weaned, cow's milk in whatever form is ingested with the daily food. Therefore, cow's milk allergies are common. They are much more significant than is generally assumed.

A true cow's milk allergy is always an allergy to the protein elements found in milk (casein, lactalbumin, lactoglobulin). Also, some people cannot tolerate lactose (milk sugar). However, this is based on an inability to digest lactose and not on allergic mechanisms. Intolerances to the fat content in milk are presently unknown. (This is the reason anyone allergic to cow's milk has no problem with **pure** cream and butter).

The **symptoms** of a milk protein allergy may vary considerably depending on the localization and severity. The "target organ" may also vary depending on where the allergy primarily manifests in the body.

The most common target organs are the **skin** (neurodermatitis in all its variations) and the **intestine** (general tendency to indigestion, diarrhea, unspecific colitis, mucosal colitis, ulcerative colitis, and many cases of Crohn's disease). In infants, a milk allergy during the first year of life is often the source of **restlessness** and b**loating**. In almost half of all "cry babies," the culprit is intolerance to cow's milk protein.

Independent of location and symptomatology, the most important step in treating cow's milk allergy is to completely eliminate cow's milk, cow's milk products, and any foods containing cow's milk.

Cow's Milk-Free Diet

This is not the simple elimination of milk and milk products such as cheese, curd, yogurt, etc. from the diet, but the complete elimination of milk information. In other words, the elimination of the biophysical frequency information that is inherent in each substance in our cosmos. Each substance has its own specific frequency information. We also refer to this as "biophysical codification." Avoiding any contact with the substance itself as well as the pure physical information is called "**avoidance of the codification.**"

We have observed that some patients are so sensitive to their allergen that even contact with the completely intangible information of the substance causes reactions from severe to most severe. This is extremely important with regard to neurodermatitis patients. The complete avoidance of

any milk information, be it hidden in the food or present in the patient's environment in whatever form, presents the actual difficulty.

The purpose of this information is to underscore the importance of the term **strict avoidance of milk** and to provide some general advice. However, it is no replacement for the constant attention and investigative work inevitable in daily life. The following list of foods that commonly or sometimes contain milk protein is by no means complete. It has to be supplemented according to a person's dietary habits and the local foods available. It is beneficial to join a local interest group or self-help group (e. g., for neurodermatitis). This is a good way to exchange information about local venues, dangers, etc. when buying from grocery and health food stores, bakers, butchers, etc.

Foods That Always Contain Milk Protein

Cow's milk, raw, cooked, pasteurized, concentrated, condensed, freeze dried as milk powder, etc. (Low fat milk powder is cheap which makes it a popular additive to many prepared and semi-prepared foods.)

All milk-based baby foods (even so-called adapted or partially adapted foods, such as NAN, Beba, Pre-Aptamil, Aptamil, Milumil, Humana) as well as so-called therapeutic food (e. g., HN-25, therapeutic food by Humana) contain low fat milk powder.

In so-called hypoallergenic (HA) food products the cow's milk protein molecule is split into smaller components. They are unsuitable for strict avoidance of the codification.

Dairy products such as curd cheese, any type of yogurt (ready-to-drink, fruit blends, smoothies), kefir, curdled milk, creme fraiche, whey, whey fruit drinks, etc., all types of cheese including parmesan and hard cheeses.

Pastries known to contain milk (milk bread, challah, potato bread, brioche, etc.), pre-baked products and snacks (crackers, pretzel sticks, etc.).

Dumplings as in bread or potato dumplings, also frozen or as semi-prepared products. All varieties of **ice cream** including soft ice cream, semi-frozen products.

Any type of **chocolate** bars.

Foods That May Contain Milk Protein

Butter: Butter actually only consists of the fat content of milk. In its **pure** form, anyone allergic to milk tolerates it well. However, experience has shown that most butter produced by large dairy farms contain traces of milk protein. Butter directly from a farmer is generally free from milk protein. However, to be on the safe side, it should be tested.

Cream: The same applies here. **Pure cream** can be tolerated. If in question, it should be tested before ingestion. Cream that is tolerable can be used as milk replacement when diluted with water. However, the lack of protein content must be taken into consideration when used on a long-term basis.

Margarine: Aside from the fact that margarine, being an industrially manufactured artificial product, is not as healthy as touted by advertising, most types of margarine contain a relatively large percentage of milk protein. Some margarines from health food stores are an exception.

Cow's milk free cheese: Almost all types of goat's cheese and sheep's cheese offered by the dairy industry, chain stores, and grocery stores contain up to one-third cow's milk (sales persons are usually unaware of this fact). To be sure, these types of cheeses should only be purchased directly from the producer (goat farmer, farmers' market).

Pasta: Pasta often causes problems. It frequently contains a certain amount of milk, which is rarely listed on the packaging. It can be assumed that all Italian pasta products (spaghetti, macaroni, ravioli, ribbon noodles, soup noodles, lasagna, etc.) are unsuitable.

Of all foods, any type of **bread** and **pastry** necessitates the most attention and suspicion. This is primarily due to fact that the rising agents bakers use are frequently made from milk. The milk content is not listed on the product and thus the baker is unaware of it. In any case, it is irrelevant in the product itself. This is a typical, vitally important example demonstrating the informational effect of the milk protein.

What does this mean on a day-to-day basis: Bake bread yourself or continuously have your bread tested!

Meat products and **sausages:** The addition of milk (commonly low fat milk powder) to sausages and meat products is prohibited according to the food law, but it happens. If in doubt, test.

Wheat flake products: Grain products (rice flakes, oatmeal, semolina products), including products specifically indicated for children's nutrition, contain traces of milk protein while no milk content is declared. Additionally, it is understood that they are meant to be mixed with milk for ingestion. This should also be notated on the packaging. To be on the safe side, small children allergic to milk should avoid these types of prepared products. Oats, rice, semolina, etc. should be used in their original unprocessed state.

Concentrates for soups and sauces: Bouillon cubes are almost always a problem for anyone allergic to cow's milk. Allergen-free bouillon cubes are available in health food stores.

Ketchup, mustard, and similar industrially manufactured products should always be tested. Some brands are prohibited.

Whey is often used when making **sauerkraut**. Hence, it must always be tested.

Important note:
Patients suffering from severe neurodermatitis, in a highly sensitive phase, may need to eliminate all types of products containing milk from their entire environment for some time. Simply the act of someone else handling milk, warming it or cooking with it, etc., releases the intangible information (the specific biophysical frequency pattern) and may subsequently cause severe reactions. When opening the door of a microwave after warming milk in it, the room is infiltrated with milk information for several hours. For these reasons anyone who is in such a sensitive stage in his/her illness must also avoid grocery stores, supermarkets, particularly dairies selling milk and cheese products. (See notations on hyperergy.)

Alternatives to Cow's Milk

Most people allergic to cow's milk tolerate **goat's milk** without any problems. It can be used instead of cow's milk for anything. Children who are exclusively or primarily fed goat's milk over an extended period of time, however, must have their hemogram checked regularly to detect the occurrence of "goat's milk anemia" (very rare) in time.

Sheep's milk is not available everywhere. It is just as good a replacement for cow's milk as goat's milk.

Mare's milk is particularly suitable for children and patients with sensitive skin. It is available frozen.

Soymilk contains high-quality vegetable protein and is mainly used for milk-free infant foods. Health food stores regularly carry a variety of soymilk products.

2 Wheat Allergy

After cow's milk, wheat is the second foreign protein that each person's body is invariably confronted with. From the second year of life the body ingests wheat daily, in some form or other. In addition, wheat is by far *the* plant that has been the most cultivated and manipulated for centuries. In all agricultural countries of the world wheat harvest ranks at the top of the economic factors. Consequently, new means and techniques are applied all the time to continually increase yields. This over-cultivation may bring large harvest yields, but at the same time it also seems to bring with it an increase in **allergen potential**. That is to say, more and more people develop allergies to components of the wheat grain. (Interestingly, allergies to spelt, the original form of wheat, are virtually unknown!)

The true wheat allergy we discussed is a hypersensitivity to **wheat protein**, the protein portion of the wheat grain. This hypersensitivity is often based on a certain genetic predisposition to allergic reactions. It is important to distinguish it from the completely different symptomatology of gliadin hypersensitivity. Gliadin is a subfraction of **gluten** contained in several types of grain (including rye, barley, oats). Hypersensitivity leads to celiac disease resulting in gastrointestinal manifestations, conspicuously bulky fatty-looking stools, and stunted growth.

The **true wheat allergy** is much more common than gliadin hypersensitivity. Surprisingly, it tends to go undiagnosed. An individual allergic to wheat rarely benefits from the more familiar gliadin hypersensitivity and its resultant large supply of gliadin-free foods. "Gliadin free" does not automatically mean "wheat free." Many gluten-free foods contain wheat starch or wheat oil for example, which anyone allergic to gliadin tolerates, yet which are strictly prohibited for any individual allergic to wheat.

The manifestations caused by a wheat allergy may vary quite significantly. The most important target organs are the **skin** (different levels of severity of neurodermatitis, specifically on the face, neck, hands, and feet) and the **bronchials** (tendency to spastic bronchitis, hypersensitive bronchial system, true "endogenous" bronchial asthma). Sometimes the intestines are also affected (colitis, Crohn's disease). Inexplicable, long-term rises in temperature, incidences of tachycardia, cardiac dysrhythmias, or phases of noticeable tiredness, etc. may be due to a wheat allergy as well.

Independent of site and symptomatology, the most important action to be taken for any wheat allergy is the complete elimination of wheat, wheat products, and foods containing wheat in the very broadest sense.

Wheat-Free Diet

A wheat-free diet does not simply mean the elimination of wheat and wheat products such as bread, pastries, pasta, etc. from the diet, but the complete elimination of wheat information. In other words, the elimination of the biophysical frequency information, which is inherent in each substance in our cosmos. Each substance has its own unique frequency information. We also refer to this as biophysical codification. Avoiding any contact with the substance itself as well as the pure physical information is called **avoidance of the codification**. We have observed that some patients are so sensitive to their allergen that even contact with the completely intangible information of the substance causes severe to most severe reactions. This is extremely important with regard to neurodermatitis patients.

The complete elimination of any wheat information, be it hidden in the food or present in the patient's environment in whatever form, presents the actual difficulty for patients allergic to wheat.

The purpose of this information is to underscore the importance of the term **strict avoidance of wheat** and to provide some general advice. However, it is no replacement for the constant attention and investigative work inevitable in daily life. The following list of foods that commonly or sometimes contain wheat is by no means complete. It has to be supplemented according to a person's dietary habits and the local foods available. It is beneficial to join a local interest group or self-help group (e. g., for neurodermatitis). This is a good way to exchange information about local venues, dangers, etc. when buying from grocery and health food stores, bakers, butchers, etc.

Foods That Always Contain Wheat Protein

Bread: Almost every bread that is purchased, even when advertised as pure rye bread, spelt bread, etc. contains some amount of wheat! This also applies to crisp breads and many other baked goods. It is best to bake the bread yourself or use only bread from a very reliable source (and test it!).

Flour: If you buy wheat-free flour (e. g., spelt, rye) in a health food store, make certain that wheat was not ground in the same grinder at any point. At home, you should also pay attention to possible residual wheat flour in the grain grinder, in containers, etc.

Wheat semolina: All types.

Baby food: Industrially prepared baby foods, unless they are explicitly labeled wheat free or gluten free.

Baked goods: Cakes, pies, tarts, waffles, basically all pre-baked goods.

Breadcrumbs: Be careful with all breaded dishes, especially off-the-shelf dishes.

Pasta: All noodles, spaghetti, macaroni, ravioli, spaetzle noodles, etc. unless they are explicitly labeled as wheat free or gluten free.

Dumplings: Frozen or pre-cooked.

Potato dumplings: With or without filling (e. g., apricot or plum filling).

Yeast dumplings: Including all similar ready-to-eat yeast-dough products.

Wheat bran: (Commonly in products which regulate the digestion).

Wheat germ: (In many health food products; for wheat germ oil, see vegetable oils!)

Wafers: Make sure you inform clergy of your child's wheat allergy! Wafers can also be made from spelt flour.

Salt dough: This is not used for eating, but to make forms and shapes. Just handling the dough may be enough to cause an allergic reaction!

Foods That May Contain Wheat

Wheat flour is added to many industrially produced foods as a thickening agent and cheap filling ingredient. It is rarely listed on the label. Look for descriptions such as cereal binder, cereal filler, cereal protein, vegetable protein, rusk, edible starch, etc.

Milk products: Yogurt (e. g., containing wheat bran or muesli), UHT milk, spreadable cheese.

Meat products: Breaded or fried meat patties, meat loaf, frankfurter sausages, any type of deli meat, any type of spreadable meat (e. g., liverwurst, pâté de fois gras), meat pasties or pies, meat conserves. All types of breaded or floured meat products.

"Hardened" vegetable fats are substances that always create errors when trying to avoid wheat. They are found in sausage-type meats and act as binders. They usually contain wheat information and are used in hard sausages or cured meats.

Prepared fish products: Fish sticks, fish loaves, breaded or battered fish.

Vegetables: Many prepared vegetable dishes, vegetable soups, etc. Canned vegetables in a sauce, instant mashed potato powder.

Soups: Prepared soups and canned soups, soup bouillons.

Sauces and spices: Spice mix for soups, curry powder.

Vegetable oils: These are given little consideration but often cause diet errors. Many high-quality oils (e. g., sunflower seed oil, corn oil, thistle oil, many olive oils) contain wheat information in some form or other. Anyone allergic to wheat should use only previously tested edible oil.

Margarine: This falls in the same category as vegetable oils. Most types of margarine based on vegetable fats contain wheat information.

Mustard, ketchup, mayonnaise, salad dressings: These are typical products containing oil and should be tested before use.

Potato chips or french fries: As pre-packaged products they are often fried in oils containing wheat.

Baking powder

Beverages: Pre-mixed cocoa drinks, cocoa powder, any milk beverages, and beer made from wheat.

Sweets: Chocolate products, prepared pudding dishes, mousse, children's deserts when sold as off-the-shelf products; chocolate bars, muesli bars, fruit bars.

Important note:

Patients suffering from severe neurodermatitis, in a highly sensitive phase, may need to eliminate all types of products containing wheat from their entire environment for some time. Simply the act of someone else handling wheat or bread, etc. releases the **intangible information** (the specific biophysical frequency pattern) and subsequently may cause severe reactions!

For these reasons anyone who is at such a sensitive stage in his/her illness must also avoid grocery stores, supermarkets, particularly bakeries and confectioners. (See notations on hyperergy.)

Wheat Alternatives

The best and most nutritious alternative for wheat is **spelt**. It is the predecessor of our cultivated wheat. However, it has a different protein molecule and therefore can always be tolerated by people allergic to wheat (excluding people sensitive to gluten!).

All other types of grain (such as rye, barley, oats, buckwheat) are generally tolerated and may be used as replacement.

When using any alternative grains pay attention to possible **contamination** caused by individual wheat grains. This may easily occur during storage, packaging, and handling.

3 Hyperergy

People's sensitivity to their allergens is not an immutable fact. On the contrary, it can vary to a large degree. Various mechanisms may cause dramatic increases in sensitivity, specifically in patients suffering from chronic allergies. This is called **hyperergy** and emphasizes the increased hypersensitivity as compared to the normal allergic reaction.

Incredibly small amounts of allergen may indeed cause severe reactions in these patients, who are usually afflicted with extremely severe neurodermatitis.

Hyperergic phases are normally short-term, but may last for several weeks or months. They often occur directly after an allergy is de-masked, that is to say at the beginning phase of avoiding any contact with the allergen. They may also occur in **times of increased stress, psychological tension, illness in the broadest sense**, etc.

Guidelines For the Avoidance of the Allergen in the Hyperergic Phase

All products containing allergens in any form whatsoever must be eliminated from the diet as well as **the home and the environment of the patient**.

Even the **handling** of the allergen—specifically **heating it up, cooking or baking** with it—by another person releases the allergen information and may cause severe reactions. When opening the door of a microwave after warming milk in it, milk information infiltrates the room for several hours. People allergic to wheat, for example, must never enter a room in which wheat-containing dishes (e. g., pasta, dumplings) have been cooked or heated, cake has been baked or wheat-bread toasted several hours before. This is another reason why all grocery stores, supermarkets, confectioners, bakeries, etc. must be avoided. Additionally, every patient should be aware of the risk of going to a restaurant. If visiting other homes, make sure that no one has handled, cooked, or baked with the allergen the same day as the visit.

In some cases, the hypersensitivity may be so severe that even contact with people who have ingested foods containing the patient's allergen may cause enormous reactions.

(In the case of hyperergic patients, we advise all members of the family living in the same home to simultaneously undergo the same strict avoidance of the allergen.)

Mothers breastfeeding their babies need to be aware that their infants may not tolerate the **mother's milk** unless she herself eliminates milk from her own diet. Testing will quickly resolve this important question.

4 Intestinal Mycosis

On the subject of allergy, intestinal fungi—almost always the yeast fungi **candida albicans**—is an important factor that always needs to be taken into consideration. Intestinal mycosis plays an important role when it comes to the severity of the symptoms and course of the disease. This applies specifically to all severe forms of chronic allergies, neurodermatitis, as well as the chronic inflammatory intestinal diseases such as ulcerative colitis and Crohn's disease.

To live, all fungi need an organic source of carbon, as they are unable to manufacture carbohydrates from carbon dioxide and hydrogen. The most important and most accessible source for organic carbon is all simple types of sugar such as dextrose, fructose, cane and beet sugar, malt sugar.

The more sugar is available to fungi, the better they grow. In one night, they can double their numbers several times, if they have a variety of sources of usable carbohydrates at their disposal as are found in any type of sweets, chocolate, pastry dishes, honey, sweet beverages, sweet fruit, compotes, jams, etc.

In addition to avoiding any food containing sugar, it is important to mechanically eliminate yeast foci in the small and large intestine. This is achieved by eating plenty of roughage whereby vegetables and salads may be eaten, cut up into very small pieces. Plant fibers are particularly effective in cleansing the system when they are ingested several times daily.

In addition to proper diet, basic hygienic measures need to be considered. Any efforts to eliminate the fungi from the intestines using an anti-fungal diet and medication are futile if carious teeth, tartar, periodontal pockets, and dental prostheses act as fungi reservoirs in the **oral cavity**. In any case, prior to any antimycotic therapy, the dentist should conduct a thorough cleaning and the toothbrush should be changed.

The guidelines presented here are based on the works by Rieth (1900). The duration of the dietary measures depends on the severity of the fungal infection. Usually, patients must strictly adhere to the diet for a minimum of 2 weeks. At the least, they must do so for the duration of the administration of antimycotic medicine. Following antimycotic therapy, they must maintain a diet with moderate sugar intake for several weeks.

Guidelines For a Fungi-Reducing Diet

The following are prohibited:

- Sugar in any form, including dextrose, fructose, honey, jams, chocolate, all kinds of pastry containing sugar such as cakes, tarts, and cookies.
- Sweet fruits (raw or cooked), especially grapes, oranges, peaches, plums, etc.
- Sweet fruit or grape juices, lemonades, cola beverages, beer, whisky, sweet wines, etc.
- White wheat products and pasta (small quantities are allowed).

The following are permitted:

- Whole grain bread, crisp bread (moderate amounts).
- Meat and sausage products (unless breaded), fish, eggs.
- Potatoes, root vegetables (raw and cooked), salads, spinach, tomatoes, cucumber, radishes.
- legumes, kohlrabi.
- Rice in small amounts.
- Sauerkraut (raw and cooked), onions, garlic, fresh herbs.
- Milk, cheese, buttermilk products (unsweetened), butter.
- Sour fruits, lemons, sour apples (no more than 1–2 per day), compotes of sour fruits (without sugar).
- Coffee, tea (without sugar), mineral water, dry wine.
- Salt and spices.
- Sugar-free sweeteners (saccharin, cyclamat).

Please note:

Wheat bran used as a laxative may cause severe bloating. Coarse whole grain breads may have that effect depending on the individual.

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